Medical Economics

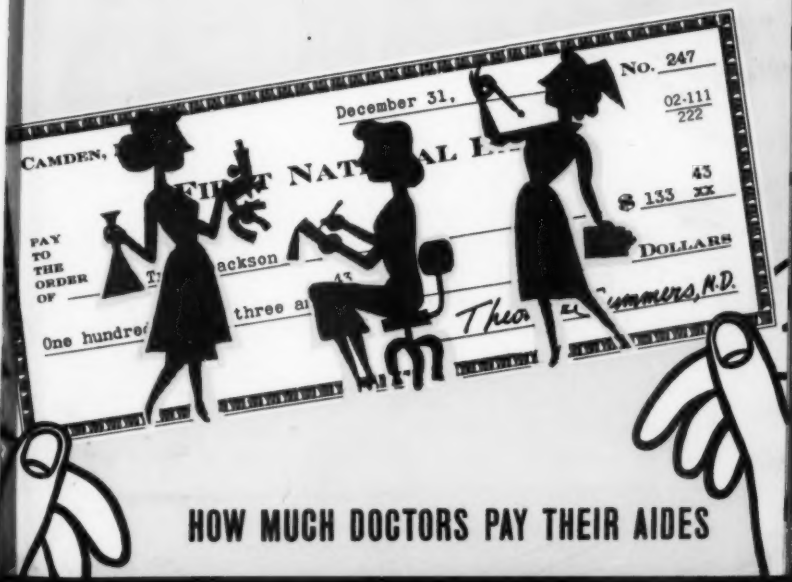
PUBLISHED EVERY OTHER MONDAY • ISSUE OF JANUARY 6, 1958

DO YOUR SAVINGS DRAW MAXIMUM INTEREST?

LEGISLATION WORTH WATCHING

G.P.S PLAN THEIR OWN CERTIFYING BOARD

U NEED WORKMAN'S COMPENSATION INSURANCE



HOW MUCH DOCTORS PAY THEIR AIDES

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PROMPT PROLONGED RELIEF

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relieves spasm pain ... the superior antacid with anti-spasmodic* action... no atropine or belladonna-like side effects.[1] **controls acid** ... the preferred antacid ... neutralizes hyperacidity promptly.[2] **promotes healing** ... the protective antacid... provides a soothing coating that covers the ulcerated area.[3] **halts erosion** ... the preventive antacid... anti-enzyme action curbs necrotic effects of pepsin and lysozyme.[4]

dosage: Adults: 2 to 4 teaspoonfuls Gel or 1 to 2 Tablets (should be chewed), every three hours as needed. **Children:** 1 or 2 teaspoonfuls Gel t.i.d.

*Bentyl—Merrell's quick-acting and safe antispasmodic.

1. McHardy, G. and Browne, D.: South. M. J. 45:1139, 1952. 2. Hufford, A. R.: Rev. Gastroenterol. 18:588, 1951. 3. Johnston, R. L.: J. Indiana M. A. 46:869, 1953. 4. Miller, B. N.: J. South Carolina M. A. 48:245, 1952.

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NEWS BRIEFS

FLUORIDATION FOES lost out last month when the A.M.A. unequivocally endorsed the fluoridation of public water supplies as "safe and practical." Dr. Lewis A. Alesen of California led the last-ditch fight against "mass medication."

123,000,000 AMERICANS now have some form of health insurance. That's more than own life insurance, the Health Insurance Institute says.

MALPRACTICE CLAIMS hitting physicians hardest in these seven states: California, Montana, Rhode Island, Washington, Arizona, Maine, and New York. In all these areas, more than 20 per cent of surveyed physicians have had claims brought against them.

NEW YEAR'S EVE ATTRACTION at Barnert Memorial Hospital, Paterson, N.J.: free coffee for all comers. Scheme included an ambulance parked out front, lights flashing, to attract passing cars.

NEWS BRIEFS

NO MORE MASS X-RAY CAMPAIGNS, the Public Health Service recommends: Not enough new TB cases are being found to compensate for radiation risks.

HOSPITAL GOVERNING BOARDS shouldn't see medical staff minutes, California doctors resolved. But last month the A.M.A. said: "The governing board . . . has the legal right . . ."

A.M.A. MAY PRODUCE a new aid to fee-setting: a value scale that rates relative worth of medical and surgical procedures in points. A committee headed by Dr. Warde B. Allan of Baltimore has been studying the idea for more than two years. Details on 147.

MANY FEDERAL GRANTS for health purposes are being dropped from the new national budget. So John A. Perkins, Under Secretary of Health, Education, and Welfare, urges states and localities to "assume a greater part of the burden."

DOCTORS ARE PAYING 10 per cent more to their aides than they paid in 1952. Salaries range from $25 to $200 a week. Details on 72.

CONSUMER SPENDING for health care, now estimated at $13,000,000,000 a year, will climb 30 per cent in the next decade if present trends hold.

JENKINS-KEOGH BILLS, offering the self-employed some tax relief on retirement savings, are due for hearings this month before the House Ways and Means Committee. But committee member Robert W. Kean, (R., N.J.) may have reflected committee attitude when he said: "Those who are looking for further retirement consideration such as the Jenkins-Keogh bills should have the basic retirement protection first—that is, Social Security."

GOT A SAVINGS ACCOUNT in a commercial bank? Most such banks still pay 2 1/2 per cent interest or less, as opposed to the 3 1/2 per cent or more you can get elsewhere. Details on 83.

GREATEST POTENTIAL THREAT to private medicine is the Forand bill, H.R. 9467—but even its sponsor doesn't think too much of its chances this year. Rep. Aime Forand (D., R.I.) has told this magazine he's "not sure" hearings will be held on his bill, which calls for Federally financed hospital and surgical care for the aged. Furthermore, "no one knows exactly" what the bill would cost. Also, the people who helped him write it "are afraid of reprisals if identified."

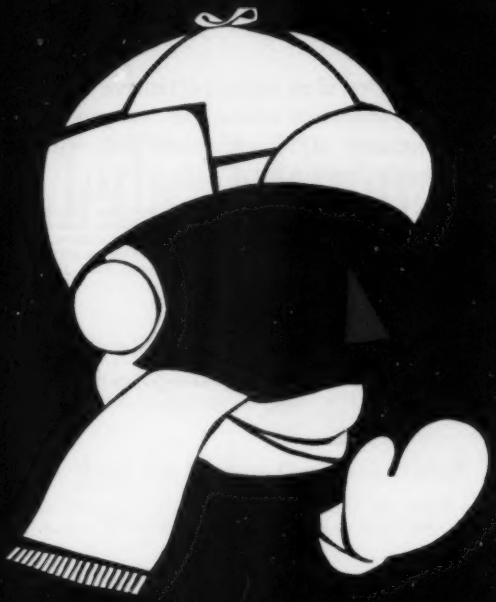
NEWS BRIEFS

NURSE-MIDWIVES should deliver most babies, Dr. John Whitridge Jr. of the Maryland State Health Department says. This would free the obstetrician from "the chore of performing duties that actually do not require his advanced skills."

NEW CERTIFYING BOARD for family physicians will be proposed and pushed hard this spring. As many as 35,000 G.P.s may be certified in the founders' group if the idea goes over. "And where will that leave some 50,000 noncertified G.P.s?" the opposition asks. Details on 69.

ARE YOU INSURED against having to pay hospital expenses and lost wages to injured office employes? If they're covered by the Workmen's Compensation law of your state, your regular liability policies won't pay off. Only a special Workmen's Compensation policy will. "Almost as important as malpractice insurance," on authority calls it. Details on 156.

NO TAX CUTS THIS YEAR, Treasury officials say. Not only that: They're asking Congress to close some "tax loopholes" that doctors, among others, have used. Deductible items under attack include (a) vacation travel combined with professional activities; and (b) interest paid on bank-loan life insurance.



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Note: As with certain other widely used nasal decongestants, overdosage may cause drowsiness or deep sleep in infants and young children: KEEP OUT OF HANDS OF CHILDREN OF ALL AGES. Tyzine Nasal Spray and Tyzine Nasal Solution, 0.1%, are not recommended for use in children under six. When using Tyzine Nasal Spray in the plastic bottle, it should be administered only in an upright position.

*Roberts, J. G.: M. Times 84:1232, 1956.

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"...alseroxylon is an antihypertensive agent of equal therapeutic efficacy to reserpine in the treatment of hypertension, but with significantly less toxicity."

Ford, R.V., and Moyer, J.H.: Rauwolfia Toxicity in the Treatment of Hypertension: Some Observations on Comparative Toxicity of Reserpine, a Single Alkaloid, and Alseroxylon, a Compound Containing Multiple Alkaloids, Postgrad. Med., January, 1958.

just two tablets
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Both combinations in convenient single-tablet form.

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JAN. 6, 1958

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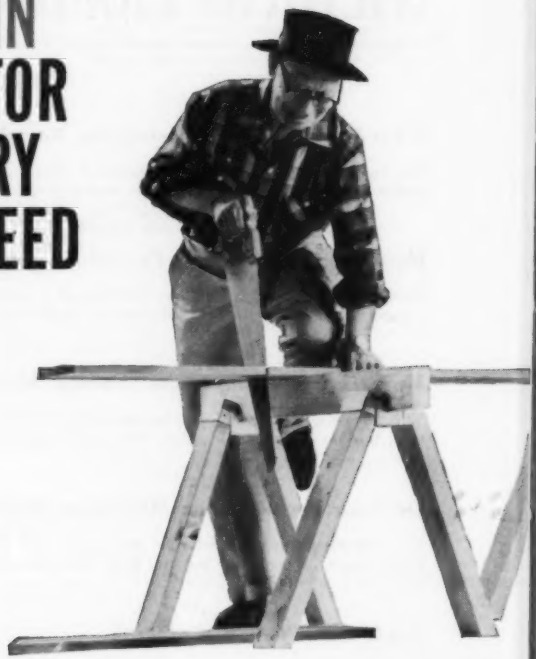

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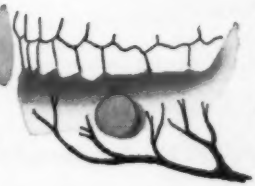
The recommended daily dose of Parenzyme **B** is 2[0] mg.—one 5 mg. buccal tablet, four times daily.

For maintenance therapy Parenzyme buccal tablets are used following initial Parenzyme injections.

For mild inflammatory conditions such as sprains, contusions, or hematomas, Parenzyme buccal may be used alone.



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The greater comfort and freedom win patient cooperation, ensure adherence to your schedule, make Parenzyme B ideal for ambulatory and maintenance therapy.

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Medical Economics

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SOUNDS AND
CYSTOSCOPES:
POSSIBLE
SOURCES OF
INFECTION

before and after urologic instrumentation

during indwelling catheterization

prophylactically in urologic surgery

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"... may be unique as a wide-spectrum antimicrobial agent that is bactericidal, relatively nontoxic, and does not invoke resistant mutants."*

■ **RAPID ACTION.** FURADANTIN, a specific for urinary tract infections, provides rapid bactericidal action against a wide range of gram-positive and gram-negative bacteria and organisms resistant to other agents including Proteus and certain strains of Pseudomonas.

■ **EXCELLENT TOLERANCE.** There have been no reports of injury to kidneys, liver or blood-forming organs as a result of FURADANTIN therapy. No cases of monilial superinfection, crystalluria or staphylococcic enteritis have ever been reported.

■ **NEGLIGIBLE DEVELOPMENT OF BACTERIAL RESISTANCE.** In six years of extensive use, development of bacterial resistance remains negligible with FURADANTIN.

AVERAGE FURADANTIN DOSAGE: In acute, complicated or refractory cases and in chronic infections of adults: 100 mg. q.i.d. In acute, uncomplicated urinary tract infections, for prophylaxis and postoperatively in urologic surgery: 50 mg. q.i.d. (If patient is unresponsive after 2 or 3 days, increase dose to 100 mg. q.i.d.)

SUPPLIED: Tablets, 50 and 100 mg., bottles of 25 and 100.
Oral Suspension, 25 mg. per 5 cc. tsp., bottle of 60 cc.

NOW for hospitalized patients, for severe urinary tract infections when peroral administration of FURADANTIN is not feasible and for serious infections as septicemia (bacteremia) when the bacterium is sensitive: *new, lifesaving*
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*Waisbren, B. A., and Crowley, W.: A.M.A. Arch. Int. M. 95:853, 1955.

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REFERENCES

(1) Chun, Y. T. and Hays, E. E. The American Journal of the Medical Sciences, August 1957. (2) Townsend, E. H., Jr. In Press. (3) Weismiller, F. In Press. (4) Cass, Leo J. and Frederik, W. S. In Press.

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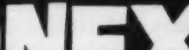

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Letters

To Biopsy or Not?

SIRS: I read "Malpractice Mishaps: the Phantom Biopsy" with considerable interest and heat. In the case described, a dermatologist removed an apparently benign mole from a woman's arm. A year later, the patient died of generalized carcinomatosis, with the primary lesion in the breast. Her husband sued the doctor for malpractice and collected $20,000.

As a practicing dermatologist, I feel that this settlement was based on two misconceptions:

The first is the idea that the doctor must *prove* a lesion benign, and that he must have a written report from a pathologist on every case of tissue removed. This just isn't practical. Dermatologists know that most moles aren't dangerous. Usually we can tell by physical examination that a mole is benign. We biopsy it only if we're in doubt.

The second misconception running through the article is that the pathologist is the "last word"—that he has only to look at a slide and, like an umpire, call it a strike or a ball. I've spent too many hours in long slide conferences not to realize that the best pathologist can't *always* diagnose a skin lesion. He often has to flip a coin to decide whether a borderline lesion is malignant. In case of doubt, he knows it's less embarrassing to call it early cancer than to find out later that what he called benign was really malignant.

Stanton B. May, M.D.
Glendale, Calif.

Insured Anesthesia

SIRS: As a physician-anesthetist in private practice, I feel compelled to comment on the views of Dr. Albert W. Snoke, as reported in a recent News column.

Dr. Snoke recommended that the Blue plans work out "a means of pooling the premium for the medical specialties of pathology, anesthesiology, radiology, and physical medicine in hospitals." He maintained that it makes no

difference whether Blue Shield pays the doctor directly or whether it pays the hospital: "The same service is given in both instances and the premium cost is the same."

I disagree. In the case of anesthesia, the same service is *not* provided in either event. Usually, when the hospital gets the money and then pays the anesthetist, it provides either a nurse or a physician who can't obtain licensure.

Valentino D. B. Mazzia, M.D.
New York, N.Y.

Wives as Patients

SIRS: By now you've undoubtedly received a number of comments about Dr. William Kaufman's article "Doctors' Wives Make Awful Patients!" May *this* doctor's wife add a few of her own?

Most of us are far too busy with families and outside activities to be the kind of neglected hypochondriacs Dr. Kaufman writes about. If we really do become ill —well, here's what happens to me:

My husband invariably picks the best specialist—and, it follows, the most successful—for me to go to. So I walk into his office with a miserable inferiority complex. He has probably squeezed me in between appointments, and I know he's not going to charge me. With the office full of paying patients, I have a horrible feeling I'm wasting his time, even though my pains are genuine.

The doctor, on the other hand, is anxious to do a thorough job on

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the wife of a colleague. He'll go to extremes in order not to miss a diagnosis. As a result, I've twice ended up in the hospital for "the works"—including a complete G.I. series—for almost no reason at all.

This sort of treatment *should* be reassuring, but I find it a bit dismaying. So I do my utmost to remain completely healthy.

M.D.'s Wife, Illinois

Rx for Prescriptions

SIRS: "Ten Ways to Prescribe Yourself Into Trouble" contained some worth-while advice. It also contained something far worse than any of the Rx errors described: the implication that the doctor should judge every professional act by whether or not it could lead to a lawsuit.

In this age of fear and looking over the shoulder, the medical profession is becoming so conscious of the lawyer, the jury, and the malpractice insurance company that we're losing our old spirit of intellectual and moral independence. It's a terrible thing to try to treat someone who is everywhere described as the potential instigator of a lawsuit. When such thoughts assail me and I put needless addresses, ages, etc. on my prescriptions, I can't help but realize that someone else is using my pen.

Clinical recognition of an insane

person or a moron should still be the measure by which we judge the nature of our prescribed directions. If a person has enough good sense to remove the wrapper from a candy bar before ingesting it, he should also be able to remove the wrapper from a suppository before inserting it.

David Leigh Rodgers, M.D.
San Francisco, Calif.

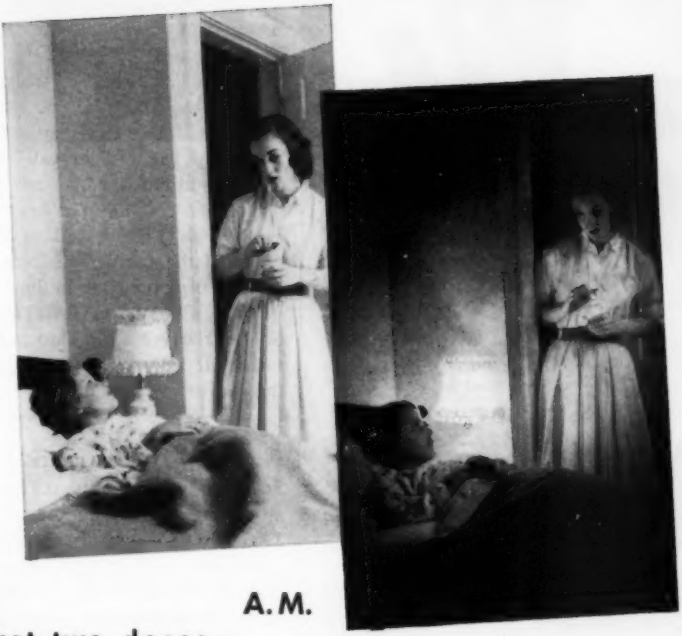
SIRS: Patients have often asked me to include on their prescriptions the purpose of the medication as well as its name. While this isn't always either practical or desirable, it can be of great use. For example, a prescription for Empirin compound with codeine, grains ½, could bear the "Sig—Tab. 1 q. 4 h. p. r. n. pain (Empirin #3)."

Thus both the pharmacist and the patient would know the purpose of the medication. On future visits or telephone calls, the physician would then be able to advise the patient whether his "white pills" were suitable for his present complaint.

S. Theodore Sussman, M.D.
New Rochelle, N.Y.

Night-Call Tip

SIRS: Doctors who've faced the problem of deciding whether a house call on a snowy night is really necessary may be interested



A.M.

Just two doses—

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in my solution: I let the patient's family decide.

As a pediatrician, I've struggled through too many a snowstorm only to find a case of diaper rash. Now, if I get a night call when road conditions are bad, *and if I suspect the call may not be necessary*, I say I'll be glad to go—provided the family will pick me up and bring me back in their car.

What if they don't own a car? So far I haven't run into such a family. If I do, I'll naturally make the call in my own car.

M.D., Delaware

National Health Fund?

SIRS: MEDICAL ECONOMICS recently reported: "The A.F.L.-C.I.O. Executive Council has formally asked that existing voluntary health agencies be federated—at least for fund-raising purposes—into a single national health fund." For the first time, I find myself agreeing with this labor organization.

Actually, it seems to me that the consolidated-health-fund idea doesn't go far enough. Probably the best answer to the solicitation problem would be an amendment to the Constitution limiting income taxes and corporation taxes. This would allow people of means to accumulate money, which would again find its way into charitable agencies, including the various research funds . . .

C. Balcom Moore, M.D.
Walla Walla, Wash.

END

RING BELL
AND
WALK IN

She returns to report . . .

full antacid benefits

–no antacid penalties

After you prescribe ALUDROX, you can expect to enter such a report as this in your follow-up record: "Acid neutralization free of drawbacks." For ALUDROX avoids systemic or other handicaps. It avoids laxation (its content of milk of magnesia is right). It avoids constipation (its content of aluminum hydroxide is right). It avoids alkalosis. It avoids acid rebound. And it solves the problem of taste resistance.

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a new drug that..

has been clinically tested in over 4900 cases of overweight

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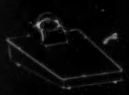
brand of 1-phenyl-2-aminopropane alginate - Nord

acts specifically on the hunger syndrome



produces an average weight loss of 2-2½ lbs. per week [1]

clinically tested . . .

by more than 700 physicians in over 4900 cases of overweight in selected University Hospitals and Clinics as well as in private practice.[2]

not a CNS stimulant . . .

unlike *d*-amphetamine, LEVONOR is not a central nervous system stimulant, but is an *anorexigenic specific* that does not cause "jitters," tenseness, or nervousness. Can be given after dinner . . . AT 8 P.M. OR LATER . . . to allay night-time hunger without disturbing sleep.[3]

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suggested dosage schedule . . .

clinicians have found LEVONOR particularly well suited to a dosage schedule of one tablet three times a day . . . at 11 a.m., 4 p.m., and 8 p.m. Some patients, especially those who have previously been treated with *d*-amphetamine, may require a temporary initial dosage of two tablets three times a day. LEVONOR offers the lattitude necessary to adjust dosage to the needs of individual patients.

available . . .

in bottles of 100 tablets, each tablet containing 5 mg. of 1-phenyl-2-aminopropane alginate.

1. Sc. Exhibit, A.M.A. Meeting, Dec. 2-6, 1957.
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3. Gadek, R. J.: Report 912:1957.
4. Sc. Exhibit, N. Y. State Med. Meeting, Feb. 18-21, 1957.

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subjectively: better tranquilization
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with fewer and less severe side effects

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New for your pediatric and geriatric patients when taste assures therapy acceptance—MODERIL ELIXIR a clear golden liquid with a pleasing lemon flavor. Each teaspoonful contains 0.5 mg.; in bottles of 1 pint.

Also available: MODERIL TABLETS, 0.25 mg., oval, scored, yellow colored, bottles of 100 and 500; 0.5 mg., oval, scored, salmon colored, bottles of 100.

References: 1. Winton, S. S.: Personal communication. 2. Smirk, F. H., and McQueen, E. G.: Lancet *2*:119 (July 16) 1955. 3. Hershberger, R. L.; Dennis, E. W., and Moyer, J. H.: Am. J. M. Sc. *231*:542 (May) 1956. 4. Moyer, J. H.; Kinard, S. A.; Hershberger, R., and Dennis, E. W.: South. M. J. *50*:499 (April) 1957. 5. Hollister, L. E.; Stannard, A. N., and Drake, C. F.: Dis. Nerv. System *17*:280 (Sept.) 1956. 6. Winton, S. S.: Internat. Rec. Med., in press. 7. Malamud, W.; Barton, W. E.; Fleming, A. M.; Middleton, P. McK.; Friedman, T. T., and Schleifer, M. J.: Am. J. Psychiat. *114*:193 (Sept.) 1957.

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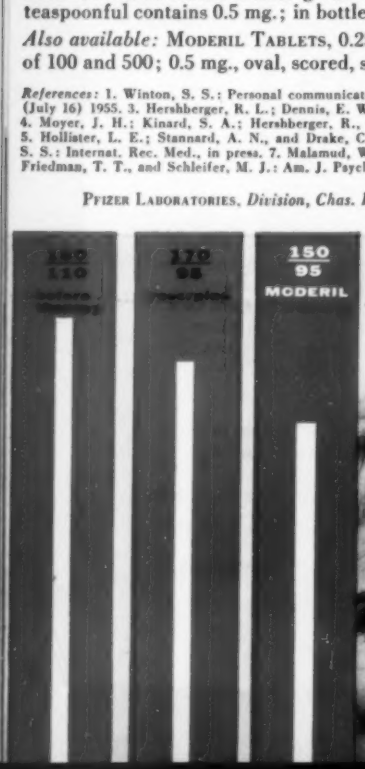
Pfizer



Y. S.,[1] a 65-year-old woman with moderate essential hypertension, with blood pressure of 180/110 before therapy. With reserpine, blood pressure averaged 170/95. Subsequent therapy with Moderil gave average readings of 150/95 to 140/90. Moderil reported as "much better . . . no side effects. . . . Excellent results in every respect."

News

'Two-Year Interneships Should Be Revived'

How can we relieve the shortage of American-educated internes? How can we teach young doctors the subtleties of patient-management? How can we persuade more budding physicians to enter general practice?

One "simple maneuver" could solve all these professional dilemmas, says Dr. Herbert Berger of Staten Island, N.Y.: "I suggest the re-establishment of the two-year rotating interneship. Hospitals to be approved for such interneship should be of 350-bed capacity or smaller, while residencies should be reserved *exclusively* for our larger institutions."

Adoption of such a program would solve the interne shortage overnight, he maintains: "There are now 14,000 approved interneships in the United States, and 7,000 graduates per year, each of whom takes a one-year, often 'straight' interneship . . . The two-year rotating service would more than fill all of these places. We may even see competition again . . ."

Furthermore, the plan would produce better physicians, Dr. Berger believes. Pointing out that "every physician must learn how to deal effectively with people before he can hope to diagnose and treat their diseases," he notes that in small hospitals the young doctor must shoulder the kind of duties he'll eventually have to face in his own practice. But in a large teaching center "the new physician has little contact with patients on his *own* responsibility." To illustrate the inadequacy of such training, he tells the following story:

Berger

He was present at a recent clinical conference in a large hospital when the discussion focused on the

case of a patient with an inoperable bronchogenic carcinoma. "I asked the chief resident—a five-year trainee—to describe what he would tell the son of this patient. [After a few false starts,] he said helplessly, 'Now, Doctor, there really isn't anything to do for him. What *do* I say?'"

Dr. Berger observes that "this young man, who represents five years' . . . training in a fine hospital, was incapable of managing this simple problem." Would two years in a small hospital have given him the experience that five years in a fine teaching center had failed to give him? The doctor thinks that it would.

The final virtue of a two-year interneship, he concludes, is that the program would probably produce more G.P.s: "The young doctor [would acquire] self-confidence and practical knowledge that he [could] always turn into a livelihood—immediately if necessary."

A.M.A. Decides Against Cuban Atrocity Protest

Would this country's doctors be stepping on the State Department's toes if they formally protested atrocities allegedly committed against doctors in another country? An indication of the answer—at least in one current instance—

an oxazine . . . not an amphetamine

appetite curbed . . .

sleep undisturbed

PRELUDIN

brand of phenmetrazine hydrochloride

developed specifically

for appetite suppression

Chemically different from the amphetamines, PRELUDIN provides potent appetite suppression with little or no central stimulation.

- **rarely causes loss of sleep**[1] — may be given late enough in the day to curtail after-dinner "nibbling," yet not hinder sleep.
- **avoids nervous tension and "jitters"**[2,3] — simultaneous sedation is not required.[3]

". . . in clinical use the side-effects of nervousness, hyperexcitability, euphoria, and insomnia are much less than with the amphetamine compounds and rarely cause difficulty."[4]

References: (1) Gelvin, E. P., McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (2) Holt, J. O. S., Jr.: Dallas M. J. 42:497, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956. (4) Council on Pharmacy and Chemistry, New and Nonofficial Remedies: J.A.M.A. 163:356 (Feb. 2) 1957.

PRELUDIN® (brand of phenmetrazine hydrochloride). Scored, square, pink tablets of 25 mg. Under license from C. H. Boehringer Sohn, Ingelheim.

GEIGY Ardsley, New York

comes from last month's A.M.A. meeting. The Association's House of Delegates decided not to vote on a resolution protesting reported atrocities in Cuba.

Through Dr. Louis Bauer, secretary general of the World Medical Association, physicians at the Philadelphia session heard that the Cuban Army has been taking reprisals against doctors who give care to wounded soldiers participating in the current rebellion. (At least two doctors have been reported murdered; another, castrated.)

Dr. Samuel J. McClendon of San Diego, Calif., then introduced a resolution protesting the reprisals. Such activities, said the resolution, violate the principle that "physicians are morally required to render immediate service" to a patient, regardless of his politics. And the reference committee that later heard testimony on the resolution recommended its approval.

But on the morning the House was to have voted on his resolution, Dr. McClendon withdrew it. His explanation: "Several delegates pointed out to me that since the matter had already been brought to the State Department's attention by the W.M.A., we'd be usurping some of the Government's prerogatives if *we* took action on it. I agreed."

One well-informed observer puts the case even more strongly: "Whatever is happening to doctors in Cuba involves more than just medicine. Politics is involved too. And unless the A.M.A. wants to get involved in another country's politics, they'd better let the State Department do the protesting."

G.P.s Have an Inferiority Complex, Poll Suggests

If more and more patients are becoming "specialist-prone," it's because "the general practitioner *encourages* this attitude."

That's the chief finding of a poll of the 130 G.P.s on the staff of Mount Carmel Hospital, Columbus, Ohio. Dr. James L. Henry, chairman of Mount Carmel's department of general practice, reports that the G.P.s "tend to refer to specialists many cases that could be cared for by the general practitioners themselves—if they had confidence in their own ability or the ability of other general practitioners."

Henry

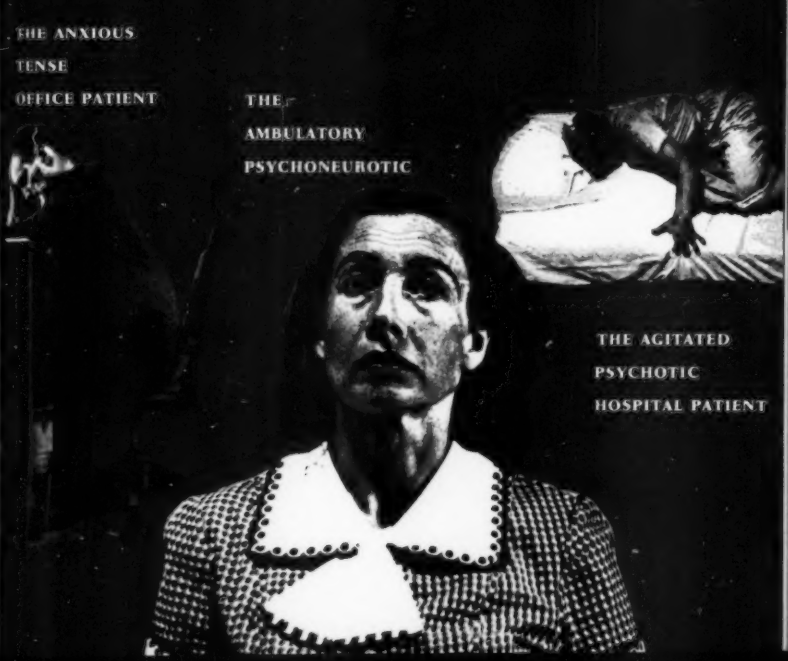
The survey shows that only one G.P. in five *ever* refers patients to another G.P., Dr. Henry complains (in a recent issue of GP magazine). What's worse from his point of view, the average surveyed man admits he prefers to send his

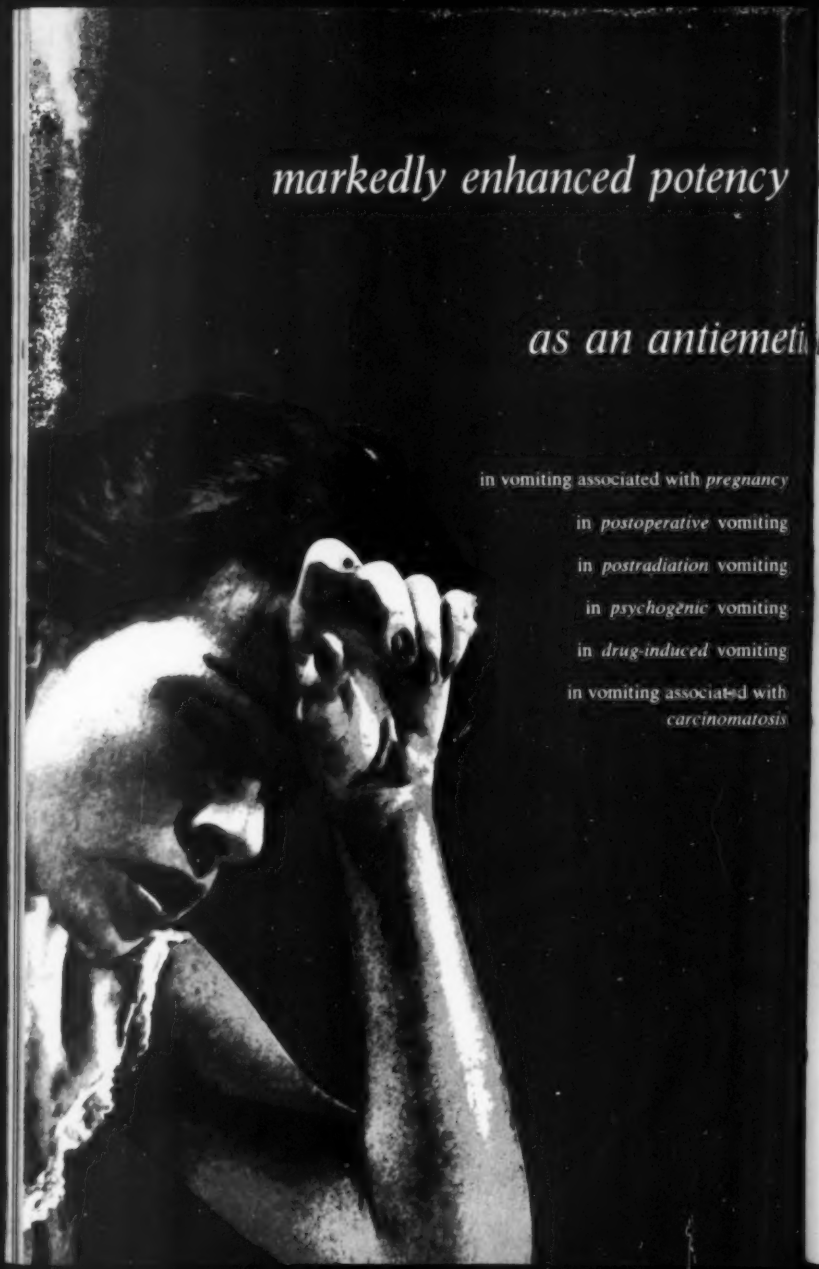
all three respond

to full-range tranquilization with

Trilafon

(pronounced Trill'-ah-fon)




markedly enhanced potency
as an antiemeti
in vomiting associated with *pregnancy*
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increased flexibility in

the full range of tranquilizer therapy

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RELIEVES PSYCHOMOTOR AGITATION IN

hospitalized schizophrenics

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mild and severe psychoneurotics

TRILAFON Tablets: 2, 4 and 8 mg., bottles of 50 and 500; 16 mg. (for hospital use), bottle of 500.

Refer to Schering literature for specific information regarding dosage, side effects, precautions and contraindications.

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CONTROL THESE SKIN CONDITIONS

AND MANY MORE

Vioform®-Hydrocortisone Cream

• anti-inflammatory • antipruritic • antibacterial • antifungal

Also newly available: VIOFORM LOTION, 3%, for patients who are sensitive to hydrocortisone or for those who do not require its anti-inflammatory, antipruritic effects; plastic squeeze bottles of 80 ml.

now also available as a **Lotion**

Supplied: VIOFORM-HYDROCORTISONE Cream, containing iodochlorhydroxyquin 3% and hydrocortisone 1% in a water-washable base; tubes of 5 and 20 Gm. Lotion, plastic squeeze bottles of 15 ml.

VIOFORM® (iodochlorhydroxyquin CIBA)

C I B A SUMMIT, N. J.

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own family to specialists. Thus, the family doctors "enlarge the scope of the specialist and diminish their own privileges."

Why this apparent lack of pride in their field of practice? One possible answer: The poll reveals that about 55 per cent of the surveyed men chose to become G.P.s because of "economic necessity." By contrast, Dr. Henry discloses, a recent post-card poll of thirty-six Mount Carmel internists showed that over 60 per cent chose *their* field in order "to practice better medicine than a general practitioner [and consequently to] get more personal satisfaction."

This last finding "was somewhat of a surprise," he observes. "My pre-poll opinion would have been that physical and economic reasons would be more prominent . . . The conclusion to be drawn from the survey is that general practitioners, in many instances, are considered 'minor league.'"

At 84, He Hitchhikes To House Calls

Dr. George W. Rall doesn't own a car. At 84, he still takes the trolley to visit his Pittsburgh patients, just as he's been doing since he started practice there in 1902. And what if the trolleys aren't running—as they weren't during a recent transit strike? He walks or hitchhikes.

Never has trouble getting rides, either. A bachelor, Dr. Rall recalls that once when he was thumbing a

INTRINSICALLY BETTER IN ANEMIA

FALVIN FEATURES A NEW KEY COMPONENT... AUTRINIC

Studies with orally administered Cobalt^{60}—labeled Vitamin B_{12} show that Intrinsic Factor Concentrates now in common use actually decrease B_{12} absorption.

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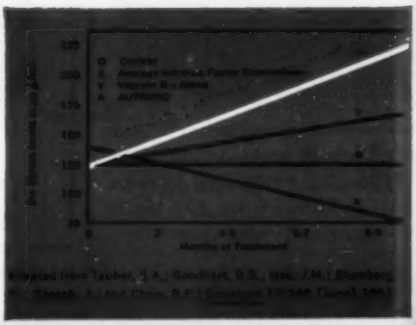

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- **BETTER GASTROINTESTINAL RESPONSE**
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Each capsule contains:	
AUTRINIC Intrinsic Factor Concentrate with Vitamin B_{12}	1 U. S. P. Oral Unit
Ferrous Sulfate Exsiccated	300 mg.
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Lederle

ride to a patient's house, "a car approached and . . . I noticed it had a lady driver. I jumped back on the curb. But she motioned for me to hop in, and I did. You know, we got along just fine. I gave her some free medical advice in exchange for the free ride."

New Item Deductible as A Medical Expense

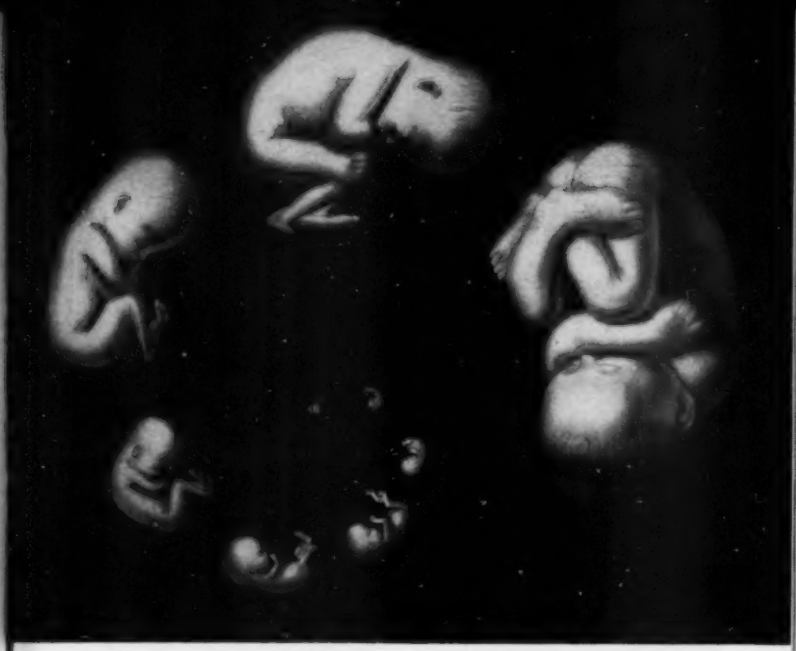
When you tell a family breadwinner he'll have to arrange for full-time home nursing, there's one small way to soften the economic blow: You can remind him that the nurse's wages—including her board—are a tax-deductible medical expense.

And that minor consolation has now been broadened: The Internal Revenue Service has ruled that Social Security taxes paid on such wages may also be deducted.

D.O.s Push for Unlimited Practice Privileges

In their fight for equal practice privileges with doctors of medicine, osteopaths are now putting new stress on two arguments. These were spelled out in recent testimony before a legislative commission in Minnesota.

Witnesses from the American Osteopathic Association argued, first, that since the Federal Government recognizes D.O.s as equivalent to M.D.s, all states should follow suit. They pointed



the 9 months that matter...

From the earliest months of pregnancy, through birth and lactation, Calcisalin offers nutritional support so important for both mother and child.

A complete prenatal supplement. Designed for routine use throughout pregnancy, Calcisalin assures important vitamin and mineral benefits. The daily dose provides

- vitamins and iron
- calcium in *usable* form
- phosphate-eliminating aluminum hydroxide

Provides usable calcium. Recent evidence indicates that phosphate-containing supplements can actually cause calcium blood levels to fall.[1-5] However, Calcisalin supplies calcium in the *usable* form of the lactate salt. To absorb excess dietary phosphorus, Calcisalin also provides reactive aluminum hydroxide gel. Thus the risk of inadvertently raising the phosphorus level to the point where it interferes with calcium absorption is avoided.

Dosage: Two tablets three times daily after meals. Available: Bottle of 100 tablets and 8-oz. reusable nursing bottles containing 300 tablets.

References: 1. Obst. & Gynec. *1*:94 (Jan.) 1953. 2. Illinois M. J. *105*:305 (June) 1954. 3. Bull. Margaret Hague Maternity Hosp. *6*:107 (Dec.) 1953. 4. Missouri Med. *51*:727 (Sept.) 1954. 5. J. Michigan M. Soc. *53*:862 (Aug.) 1954.

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WARNER-CHILCOTT
100 YEARS OF SERVICE TO THE MEDICAL PROFESSION

out that both the Veterans Administration and the Public Health Service place medical and osteopathic doctors on the same scale. And they quoted Dr. Frank Berry, assistant secretary of defense for health and medicine, as having told a Senate committee he had no objection to appointment of D.O.s as military medical officers.

The second argument was brought forward by E. C. Goblirsch, D.O., chairman of the Minnesota osteopaths' Bureau of Public Education on Health. "The interests of public health should be paramount to the interests of the medical profession," he declared. Yet Minnesota's unequal laws are driving much-needed osteopaths into states where they *do* have a right to unlimited practice, he held.

Nowadays, osteopathic training "is superior or identical to that given in medical schools," argued Dr. Goblirsch. "Only with unlimited licenses can the [osteopathic] profession be allowed to contribute its maximum to public health."

State Steps Up Action Against Quacks

If your state doesn't have a strictly enforced law against unlicensed medical practitioners, it may be getting an influx of them soon. Reason: The Illinois quacks are going to have to move elsewhere.

Illinois has now tightened its medical practice act in a number of ways. Not only will unlicensed

announcing...

Novahistine LP* *tablets*

patients with colds... sinusitis ... rhinitis will appreciate the "Novahistine LP Effect"

When a patient begins breathing freely in a few minutes ... with all air passages cleared ... and this relief continues for as long as 12 hours after a single dose ... he is experiencing the "Novahistine LP Effect."

This "Effect" is produced by phenylephrine hydrochloride, a quick-acting, orally effective sympathomimetic, combined with chlorprophenpyridamine maleate, a potent histamine antagonist for synergistic decongestive action ... on all mucous membranes of the respiratory tract.

Each Novahistine LP Tablet contains:
Phenylephrine hydrochloride ..... 20 mg.
Chlorprophenpyridamine maleate ..... 4 mg.

Supplied in bottles of 50 tablets.

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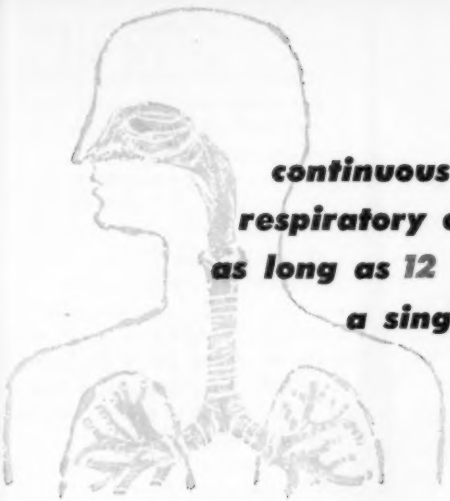
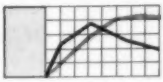
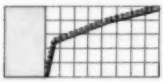


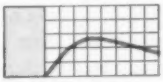
continuous relief of respiratory congestion for as long as 12 hours with a single dose



PROMPT RELIEF
Novahistine LP Tablets start releasing medication almost as rapidly as a solution.



CONTINUOUS RELEASE
Novahistine LP releases its decongestive drugs at a constant rate in both acid and alkaline media . . . assuring patients continuous relief whether the tablet is in the stomach or intestine.



SAFE RELIEF
With Novahistine LP there is no sudden "over-release" . . . no uneven, sporadic effects.

And easy to use, oral dosage eliminates patient misuse of nose drops, sprays and inhalants . . . is not likely to produce rebound congestion, mucosal damage and ciliary paralysis, nor make the patient "jittery."

Administration: Adults—2 tablets twice daily will provide an adequate therapeutic effect in the average patient. In resistant cases, a third daily dose may be indicated and can be safely given. Children over six—one-half the adult dose.

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practitioners be more vigorously prosecuted; several new preventive measures go into effect on July 1 of this year. Among them:

Licensing examinations are to be made much more thorough. Once licensed, a doctor will have to register with the state. He'll be required to reregister every two years. Finally, the state plans to publish—and to disseminate widely—an annual roster of licensed persons. The roster will include an up-to-date list of licenses suspended or revoked.

The above regulations have the full approval of Illinois doctors. It's just as well, since they'll have to foot the bill: The state fee for licensure examinations has been upped from $10 to $50, and the biennial registrations will cost $6 each.

Britain Presses Doctors To Be Cost-Conscious

One big talking-point for state medicine is that doctors under it needn't worry about costs in treating their patients. But now that Britain's National Health Service is firmly established, this argument appears to have lost some of its force. In fact, doctors are being blamed for waste and extravagance in the N.H.S. For instance:

Parliament's Select Committee on Estimates has reported to the Minister of Health that drug prices in Britain have gone down 13 per cent since 1954—but that hospital drug expenditures have gone *up*

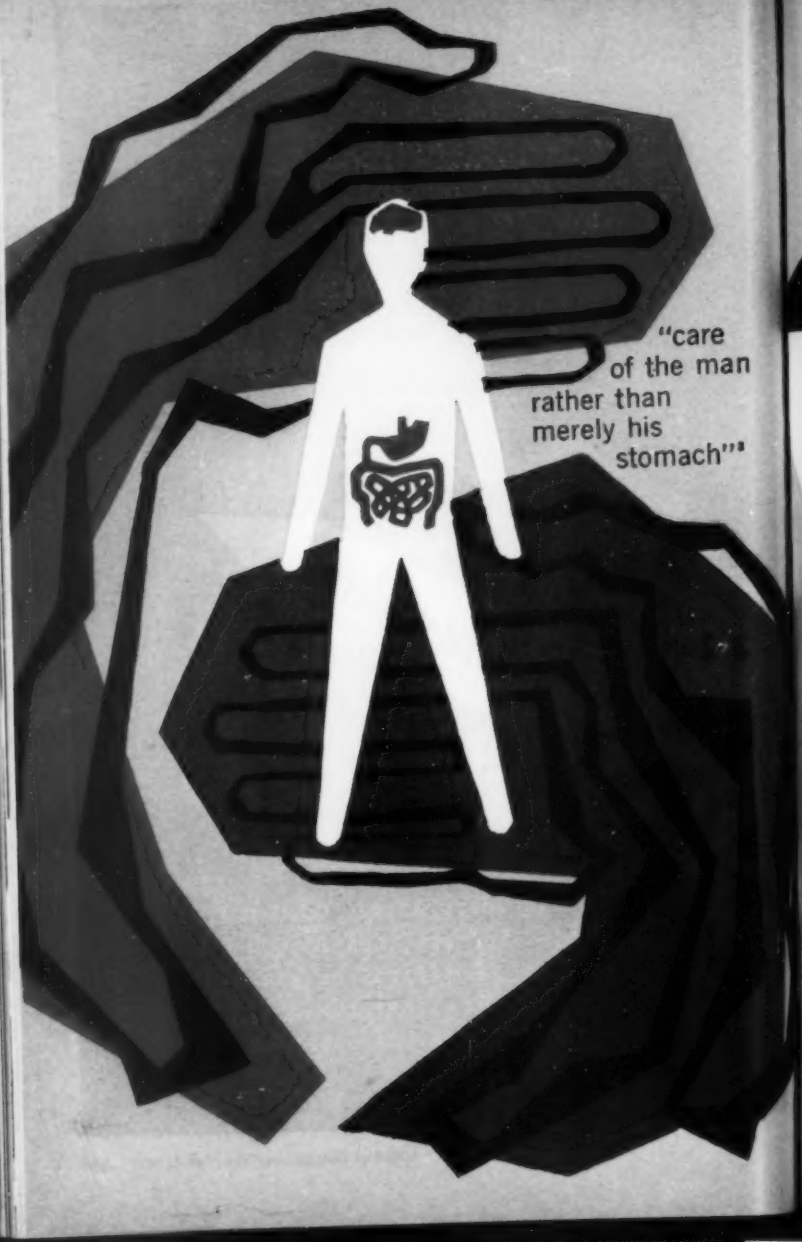
more than 15 per cent. It doesn't do any good to ask doctors to keep costs down, the committee complains; doctors just "lack cost consciousness."

How can they be made cost-conscious? Says the committee: "The problem can only be solved at the source—by ensuring that no medical student qualifies as a doctor without being made aware of the financial responsibilities of his position in the Health Service, and of the costs of the treatments he will have to prescribe." Its recommendation: that examinations for medical licenses henceforth include questions on "the financial structure of the N.H.S."

Free Care? People Won't Use It, Study Shows

It's assumed in many quarters that if the financial barrier to preventive medicine were lifted, the average layman would "seek medical care in proper time." But one city's experience seems to explode that myth.

Too many laymen simply aren't aware of their health needs, says Dr. (SC.D.) Matthew Tayback, Assistant Commissioner of Health for Research and Planning in Baltimore. To illustrate, he tells about a recent survey of 800 Baltimore residents. The surveyed individuals were first asked to estimate the state of their health; and they were then given clinical examinations. Dr. Tayback reports: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of the man
rather than
merely his
stomach"

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two-level control of gastrointestinal dysfunction

at the central level The tranquilizer Miltown® reduces anxiety and tension.[1, 3, 6, 7]
Unlike the barbiturates, it does not impair mental or physical efficiency.[5, 7]

at the peripheral level The anticholinergic tridihexethyl iodide reduces hypermotility and hypersecretion.
Unlike the belladonna alkaloids, it rarely produces dry mouth or blurred vision.[2, 4]

indications: peptic ulcer, spastic and irritable colon, esophageal spasm, G. I. symptoms of anxiety states.

each "Milpath" tablet contains:

Miltown® (meprobamate WALLACE) ..... 400 mg.
(2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate)

Tridihexethyl iodide ..... 25 mg.
(3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)

dosage: 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

available: bottles of 50 scored tablets.

references: 1. Altschul, A. and Billow, B.: The clinical use of meprobamate (Miltown®). New York J. Med. 57:2361, July 15, 1957. 2. Atwater, J. S.: The use of anticholinergic agents in peptic ulcer therapy. J. M. A. Georgia 45:421, Oct., 1956. 3. Borrus, J. C.: Study of effect of Miltown (2-methyl-2-*n*-propyl-1,3-propanediol dicarbamate) on psychiatric states. J. A. M. A. *157*: 1596, April 30, 1955. 4. Cayer, D.: Prolonged anticholinergic therapy of duodenal ulcer. Am. J. Digest. Dis. *1*:301, July 1956. 5. Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Experimental studies of behavioral effects of meprobamate on normal subjects. Ann. New York Acad. Sc. *67*:701, May 9, 1957. 6. Phillips, R. E.: Use of meprobamate (Miltown®) for the treatment of emotional disorders. Am. Pract. & Digest Treat. 7:1573, Oct. 1956. 7. Selling, L. S.: A clinical study of Miltown®, a new tranquilizing agent. J. Clin. & Exper. Psychopath. *17*:7, March 1956. 8. Wolf, S. and Wolff, H. G.: Human Gastric Function, Oxford University Press, New York, 1947.

WALLACE LABORATORIES
New Brunswick, N. J.

"None of a group of patients with disease of the prostate was sufficiently aware of the disturbance to report it; 80 per cent of those with cataract, but not blind, were unaware of their predicament; and some 60 per cent of individuals with hypertensive heart disease were similarly not cognizant of their condition."

What's more, he adds, many people won't see a doctor even when offered free care. "Seven thousand persons aged 17 years and over were invited to a screening clinic," he reports. "[It was] in a centrally located office and operated at hours suitable to the convenience of the individuals canvassed. After persistent follow-ups, including telephone calls and home visits, 2,024—or only 29 per cent—finally were seen . . . [Yet] the examinations were free of charge and transportation was offered when needed."

Revised Welfare Law May Hurt Some Doctors

When Congress tinkers with the Social Security Act, watch out. Its revisions may *seem* to promise a better deal for physicians; but there's often a fly in the ointment. For instance:

Recent changes in the Act make some $200,000,000 of new money

High-concentration topical salicylate-menthol therapy (BEN-GAY) offers safe, penetrating relief of painful joints and muscles resulting from overexertion.

New, objective evidence:

A double-blind study[1] has reaffirmed the exceptional efficacy and safety of conservative, local treatment of chronic rheumatic disorders with BEN-GAY® (BAUME BENGUÉ), a high-concentration salicylate-menthol compound.

The local and systemic effects of BEN-GAY were evaluated by entirely objective methods in 211 subjects of both sexes suffering from various types of chronic arthritis, bursitis, neuralgia, myalgia and lumbago. Changes in range of joint motion were determined by goniometer and by flexion. Topical application of BEN-GAY measurably improved articular function in 94% when physical therapy was also used, and in 61% without adjunctive treatment. Efficient absorption of salicylate through the skin was indicated by an average urinary excretion of 15 mg. in 24 hours. No ill effects were reported or observed.

Benefits of Topical Salicylate

in chronic rheumatic disease

Menthol-induced hyperemia plus high local concentration of salicylate has been recently rediscovered as one of the safest and most promptly effective remedies for rheumatoid discomfort due to exposure.

This controlled study offers new evidence of the efficacy and safety of local treatment of chronic rheumatic disease with BEN-GAY, one of the safest and most reliable formulae at the physician's disposal. BEN-GAY is available in two strengths, *Regular and Children's*. THOS. LEEMING & CO., INC., 155 East 44th St., New York 17, N.Y.

[1]Brusch, C.A., et al.: Md. State Med. J.; 5:36, 1956.

***More efficient salicylate penetration* of treated area and quicker relief of pain is now made possible by water-washable, new GREASELESS-STAINLESS BEN-GAY.**


NOW,
FROM
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A NEW
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UNEXCELLED
ANTIHISTAMINE
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Di'me tane

why Dīmetane is the best reason yet for you to re-examine the antihistamine you're now using

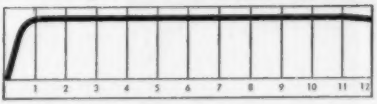
» *Milligram for milligram, DIMETANE potency is unexcelled.* DIMETANE has a therapeutic index unrivaled by any other antihistamine—a relative safety unexceeded by any other antihistamine. DIMETANE, even in very low dosage, has been effective when other antihistamines have failed. Drowsiness, other side effects have been at the very minimum.

unexcelled antihistaminic action

Diagnosis	No. of Patients	Response				Side Effects
		Excellent	Good	Fair	Negative	
Allergic rhinitis and vasomotor rhinitis	30	14	9	5	2	Slight Drowsiness (3)
Urticaria and angioneurotic edema	3	1	1	1		Dizzy (1)
Allergic dermatitis	2		1	1		Slight Drowsiness (2)
Bronchial asthma	1		1			
Pruritus	1		1			
Total	37	15	13	7	2	Drowsiness (5) Dizzy (1) 16.2%

From the preliminary Dimetane Extentabs studies of three investigators. Further clinical investigations will be reported as completed.

a blanket of allergic protection, covering 10-12 hours—with just one Dīmetane Extentab



Periods of stress can be easily handled with supplementary Tablets or Elixir to obtain maximum coverage. Extentabs 12 mg., Tablets 4 mg., Elixir 2 mg. per 5 cc.

DOSAGE: Adults—One or two 4-mg. tabs. or two to four teaspoonfuls Elixir, three or four times daily. One Extentab q.8-12h. or twice daily. Children over 6—One tab. or two teaspoonfuls Elixir t.i.d. or q.i.d., or one Extentab q.12h Children 3-6—½ tab. or one teaspoonful Elixir t.i.d.

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available each year for the medical care of persons who've been chiefly charity cases: the recipients of Public Assistance aid. Further, the money is to be paid directly to the "vendors of medical service," not to the patients. But because the new law supplements the long-standing Social Security program under which state payments for Public Assistance are matched by Federal grants, there's a catch in it.

Under the old program, the states were free to earmark part of their general welfare funds for medical expenses of indigents; but there was no special provision for medical payments as such. Now that there is such a provision, you might expect to benefit from it. Instead, if you live in any one of fifteen states,* you're likely to get *less* money than heretofore for Public Assistance cases. The reason:

Those states are already paying more medical care money directly to doctors than the top amount allowed under the new program. And because of highly complicated bookkeeping provisions in the revised law, they can no longer pay doctors directly under the *old* program in addition to participating in the *new* one.

MORE ▶

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So physicians in at least some of the fifteen states may now expect to get only part of their Public Assistance fees directly. They'll have to collect the rest from their indigent patients—if they can.

G.P. Lends His Office to Specialist Consultants

A new way to handle referral situations: General Practitioner Howard F. Long of Dixon, Calif., has specialists hold "clinics" in his office. So far, he has used the system for consultations in cardiology, endocrinology, gynecology, pediatrics, and psychiatry. And he believes "it would have apparent advantages in other fields" as well. Here's how it works:

At the end of each day, he makes a list of those patients with nonacute problems who he thinks would benefit from consultation. When he has collected three to six problems in the same field, he asks an appropriate specialist to spend part of a specified day at his office. Then he asks the patients to make appointments for that day. "Most accept this better than the usual referral," he says.

When the specialist arrives, Dr. Long gives him a room to himself. The G.P. continues to see his own regular patients. Before each referred patient leaves the office,


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"plans are made jointly for further evaluation or treatment."

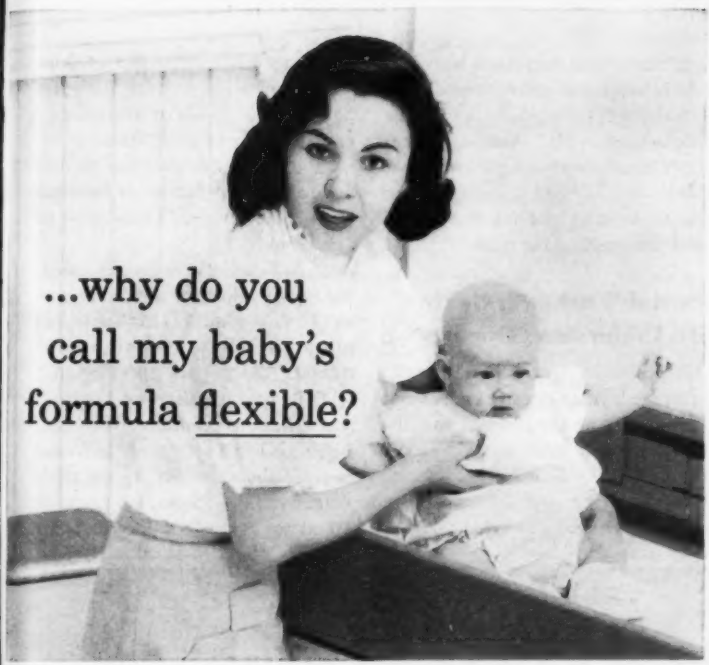
The notes and comments of the specialist are transcribed for both doctors. As for billing, "usual bills are sent by both doctors to the patient," explains Dr. Long. "And if travel time for the specialist is involved, charge for this time is divided among the patients."

As he sees it, there are three major advantages to such an arrangement:

1. *The specialists* benefit because, in addition to getting more referrals, they develop a better working relationship with the referring doctor. They see patients who've already been worked up and who are reassured by familiar surroundings and personal introduction by their family physician. And, of course, it helps to have the G.P. at hand with his records and recollections of the patient and his background.

2. *The G.P. himself* benefits because he "keeps responsibility for the total care of his patients." In addition, says Dr. Long, his medical education continues in the best possible way, because it's oriented to his own patients. The recommendations he gets from the specialist are more complete and practical than they would be in the usual written report.

3. *The patients* benefit most of all. Dr. Long reports he detects



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problems "that might not be found if [I] were not actively searching for them in the preparation for the consultant's visit." And his system of referral convinces patients "that their own doctor is interested in them, looking out for them, and not just 'passing the buck.'"

Social Worker Tells How To Understand Doctors

It's probably a good thing that the average layman doesn't know what you're talking about when you discuss medical matters in medical terms. But social workers aren't average laymen. And some of them apparently are troubled at their inability to make sense out of doctors' reports on welfare patients. Says Mary E. Davis of Minnesota's Department of Public Welfare:

"I often think that we should add to our medical report form an item called 'English Translation of the Above.'"

Most caseworkers are mystified, she says, by doctors' notations such as "C.V.A.-remote, intracranial aneurysm, hypertension controlled." Or "S.O.B. on exertion." (S.O.B. means "short of breath," she hastens to point out.)

Miss Davis admits she's found doctors always willing to put their diagnoses in simple language if asked to. "But let's face it," she

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says. "We're all afraid of doctors."

What, then, should the caseworker do to "overcome the barriers of communication"? She should *not*, Miss Davis emphasizes, retaliate with her own jargon: "verbalize, sibling, ambivalent," etc. Instead, the caseworker is advised to find someone who can interpret the doctor's reports for her:

"If the local agency has no medical social worker, the best interpreter . . . is the public health nurse . . . Another interpreter . . . is the doctor's own office nurse. She not only has the key to his office, but frequently the key to him."

G.P. vs. Internist: Who's The Family Doctor?

The nation's general practitioners are evidently determined to head off the internists in the race for public recognition as "the modern family doctor." Dr. John S. DeTar, past president of the American Academy of General Practice, has urged his fellow-G.P.s to consider meeting the challenge by taking three drastic steps right away: (1) They should raise educational standards in general practice; (2) create a board for family physicians*; (3) change the name of the A.A.G.P. to the American Academy of Family Physicians, or something similar.

*See "G.P.s Plan Their Own Certifying Board," page 69, this issue.

"We don't have time to wait a few months," he warns. In support of his proposals, he quotes a letter from Dr. R. A. Davison, head of the general practice department at the University of Tennessee College of Medicine:

"The internists believe they should and will be the family physicians of the future. They are out to gain public acceptance in this regard. The American College of Physicians and the American Board of Internal Medicine can [not] gracefully promote the 'family doctor' ends of the internist. So a new organization, the American Society of Internal Medicine, is apparently designed to [do this].

"If the internist develops an 'American Board of Family Physicians' as a subspecialty board of internal medicine, we as members of the Academy can consider ourselves 'scooped,' as the reporters would say. Hospital privileges would be a lost cause for the future; and public opinion would be split between two groups—both claiming to be the modern family doctor."

At present, Dr. DeTar concludes, neither group has the inside track: "I believe that some place along the way, we are going to arrive at a family physician who has had more training in internal medicine or an internist who has had more training in general medicine." END

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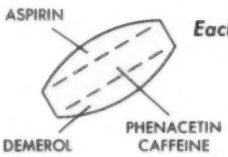

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, JAN. 6, 1958

This time a strong group means business. You can look for some definite action this spring—complete with fireworks

G.P.s Plan Their Own Certifying Board

By Lois R. Chevalier

"How good a physician is Jones?"

"He's pretty good. He's a diplomate of the American Board of General Practice."

Impossible conversation? Maybe not.

At the next annual meeting of the American Academy of General Practice (March 22-26 in Dallas), G. P. leaders expect to propose a certifying board for family physicians. A special committee has already discussed the idea with the A.M.A. Council on Medical Education and Hospitals, which is the final authority on the setting up of new boards.

The idea has bobbed up many times in the past. But

never before has it had anything like the sustained support that the powerful Academy of General Practice can give it. Never before have so many practical questions connected with the idea been worked over so carefully in advance.

Privileged 'Founders'

The question of greatest interest to most doctors is probably this: How many of today's 86,000 general practitioners will be certified without examination by the new board? In other words, how many will be "blanketed in" as founders?

One past president of the G.P. Academy says: "A number of general practitioners will be invited to be founders—but probably not all of the 22,000 Academy members."

Non-Members Too

What about the 64,000 general practitioners who aren't Academy members? Obviously, there are a lot of good family doctors among them. No one has said they won't be eligible for "blanketing in" with the founders' group.

All present signs suggest, however, that at least 50,000 family physicians will be left out in the cold. Unless they take post-graduate training to meet the new board's requirements, they may well become medicine's second-class citizens, some physicians fear.

These doctors are saying that an American Board of General Practice will make the license to practice medicine virtually meaningless. With a new class of G.P.s who have board diplomas besides, what hospital staff will take in the general practitioner who is merely licensed to practice by the state?

Older G.P.s Safe

This question hasn't stopped the men who are spearheading the new board. "It won't make any difference to older practitioners like myself," one of them contends. "I've already built a practice. I already have my privileges in the hospital. So have my contemporaries.

"We're doing this for the younger men. If they can't be assured some status and security, they just won't go into general practice. And as long as hospital staff applications have a blank for board certification and family physicians have to leave it blank,

they'll be discriminated against."

Sponsors of the new board have some other problems to lick. The two most pressing ones are the problems of defining general practice and of setting up training requirements. As to the former, one Northwestern G.P. who's working on the project says:

One Definition

"We're specialists in common medical, surgical, obstetrical, and emotional problems, without prejudice as to age, sex, or portion of the body involved."

Another sponsor doubts that this kind of definition will stand up nationally. "In the East," he says, "only 5 per cent of the family doctors do major surgery. In the West and South, a hernia is a 'common' surgical problem for the G.P."

The Kind of Training

Once the sponsors agree on an adequate definition of general practice, they'll have to decide what hospital training their new board will require for certification.

"The interneship is on its way out," says one spokesman. "The senior year of clinical clerkship has made it obsolete. We're working toward a two-year residency requirement for certification in general practice."

Not Enough?

This may not be enough to suit medical officialdom. One nationally known surgeon who has a vote in the establishment of any new board has this to say about the problem:

"It *might* be possible to cram enough graduate training for general practice into three years. I can foresee a program that would give G.P.s a broad base in medicine and surgery in the first two years. Then they'd need at least one more year to learn something about the surgery of trauma, some cardiology, some obstetrics, and perhaps some psychiatry.

"Don't misunderstand me," he adds. "I'm glad to see general practitioners thinking about a board. It's much more constructive than a political battle for privileges in the hospital. This is the beginning of something good. But they'll have to realize that no one will take them seriously unless they're willing to establish a graduate training requirement comparable [MORE ON 190]

How Much Do Doctors Pay Their Aides?

By Arthur Owens

EDITOR'S NOTE: The typical physician in private practice spends almost $4,000 a year for full-and/or part-time office help, according to MEDICAL ECONOMICS' 8th Quadrennial Survey. But *how* does he spend this money? What does he pay a nurse as opposed to what he pays to a technician or a bookkeeper? How much difference is there between the salary of a typical G.P.'s aide and that of a typical specialist's aide? And how much difference does his type of practice or the size of his community make?

You'll find answers to these and related questions in the following article. It's the first of a series based on a new MEDICAL ECONOMICS study of doctors' personnel practices in some 600 U.S. medical offices. Purpose of the study: to get a comprehensive picture of the physician as an employer. Later reports will examine aides' work-

ing hours, the rate at which their salaries increase, their fringe benefits, and the qualifications doctors say they look for in office help.

All figures shown here are median weekly salaries for 1957. And only aides who regularly work thirty-five or more hours a week have been included in the tabulations that accompany this article.

More doctors are paying more money to more office assistants than ever before. MEDICAL ECONOMICS' most recent Quadrennial Survey indicated that fully 81 per cent of all privately practicing physicians employed at least

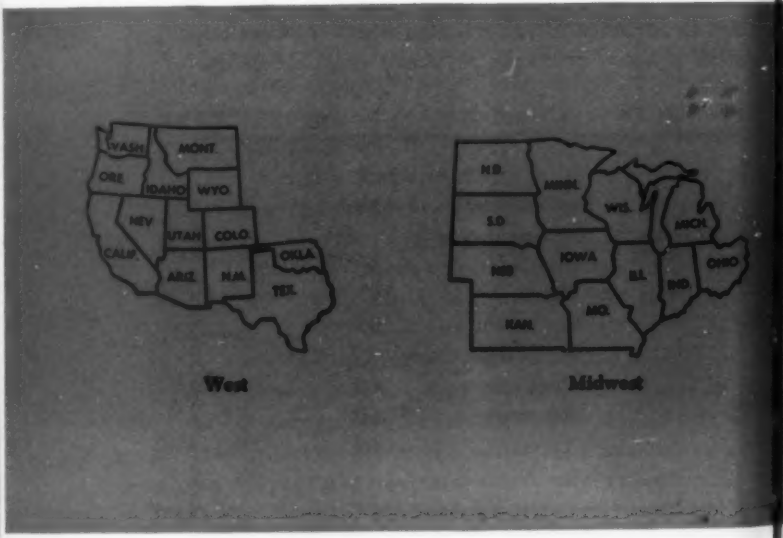
Typical Salaries of Aides
By Job Title

Nurse	$65
Technician	65
Medical secretary	62
Bookkeeper	60
Receptionist	60
Typist	60

one full- or part-time aide. The comparable figure for four years earlier: only 75 per cent. In the same four-year period, the typical physician's office payroll increased by nearly one-half.

Salary raises account for a portion of the hike. But it's apparent that a good-sized chunk of the individual doctor's growing payroll now goes for *additional* help. Some 40 per cent of all self-employed physicians had two or more non-M.D. assistants in 1956, as against about 25 per cent in 1952.

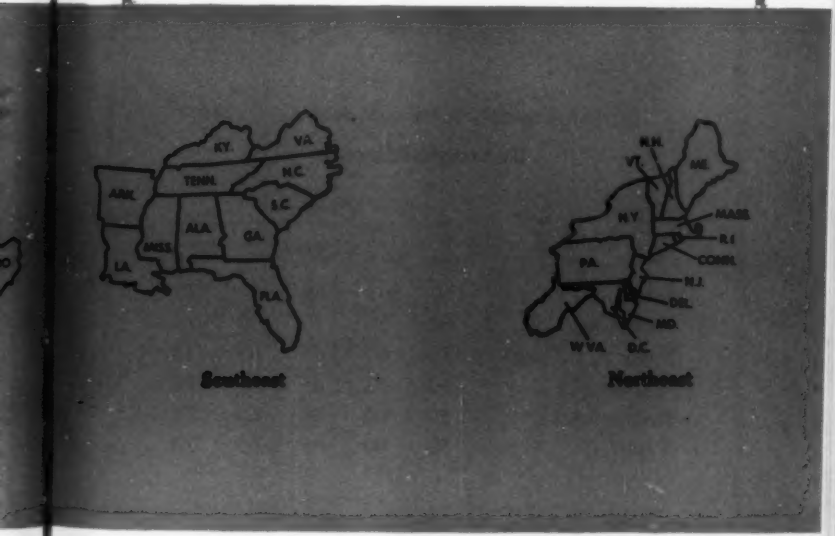
How much does the typical doctor pay his aide? MEDICAL ECONOMICS' newest study shows that the nationwide median ranges from $60 to $65 a week, depending on the aide's duties. This represents an increase of roughly 10 per cent since 1952. So it's apparent that the sala-



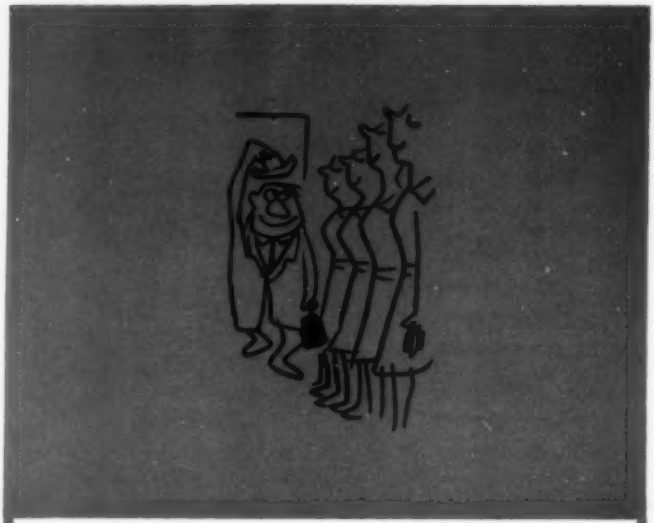
Typical Salaries of Aides

By Region

	West	Midwest	Southeast	Northeast
Nurse	$69	$67	$60	$65
Technician	69	60	60	65
Medical secretary	68	60	58	60
Bookkeeper	62	60	58	62
Receptionist	60	58	50	60
Typist	65	59	57	60



MORE ▶



Typical Salaries of Aides
By Length of Service

	Period of Employment				
	Less Than 1 Year	1 to 2 Years	2 to 5 Years	5 to 10 Years	Over 10 Years
Nurse	$60	$62	$69	$75	$75
Technician	50	60	70	70	70
Medical secretary	50	60	65	68	73
Bookkeeper	50	62	65	60	75
Receptionist	50	60	60	60	71
Typist	50	60	65	65	73

How Much the Typical G.P. and Specialist Pay Their Aides

	G.P.	Specialist
Nurse	$63	$69
Technician	60	70
Medical secretary	60	65
Bookkeeper	60	65
Receptionist	54	60
Typist	60	60

MORE ▶

ries of medical workers are being regularly adjusted to meet repeated rises in the cost of living.*

Although going rates vary by region, community size, length of service, and the employer's field of practice, the *average* variation seems narrower than you might expect. But the study has turned up some spectacular contrasts in individual offices. Consider the following extremes:

¶ A country G.P. in Oklahoma reports that he hired his present Girl Friday ten years ago at $10 a week. He now pays her $25 for a forty-five-hour work-week, throwing in an occasional bonus for good work. But he allows her no time off for vacation or sick leave. But he does give her time off later for working overtime.

*The Consumer Price Index, official barometer of the cost of living, has shown a rise of 5.6 per cent since 1952.

Typical Salaries Paid by Doctors With Only One Aide

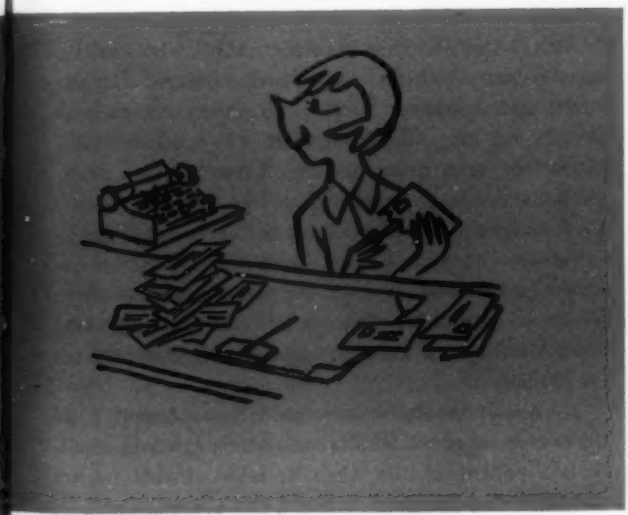
Region	Metropolitan	Urban	Suburban	Rural
West	$70	$65	$69	—
Midwest	65	60	—	$50
Southeast	60	57	—	—
Northeast	60	—	65	60
All U.S.	65	60	65	50

Where no figure is given, sample was inadequate.

¶ A New Orleans surgeon says *he* pays his aide $200 for a forty-hour week. (He started her at $165 two years ago.) In addition to salary, she gets occasional bonuses and a percentage for collecting overdue accounts. Last year he gave her five weeks' vacation (three with pay) and five paid holidays.

Comments the New Orleans man: "Too many doctors aren't getting the kind of help they need because they don't pay enough. If my aide were well enough qualified, and if she'd really put forth the effort, I'd be willing to raise her pay even more. And if she stays with me, she'll get retirement pay after thirty years."

But his standards are admittedly unusual. To compare the salaries in your office with those paid by the *typical* doctor in similar circumstances, see the accompanying tables. END



Take a lesson from these

13. THE CASE OF

By Xavier F. Warren

EDITOR'S NOTE: *Here's the thirteenth in a series of true incidents selected from the confidential file of a malpractice insurance company's claims adjuster. Although names and identifying details have been changed, the stories accurately portray recent cases.*

Dr. Ben Galliet was a highly respected G.P. who'd helped many patients with their emotional problems. He was warm, understanding, tolerant. He always made such patients feel they were being treated as sensible adults. "Show 'em you trust 'em and they'll trust you," he'd say.

That was one of the secrets of Ben Galliet's success. Yet it was the source of a malpractice suit against him.

Preston Humbleman was a well-known business executive in Dr. Galliet's town. He was also a well-known alcoholic. Periodically he'd go off on a heavy drinking bout. After one particularly rugged round, he went to see Dr. Galliet.

The doctor and the businessman talked at length. Then the doctor suggested disulfiram—which I'm told conditions a patient so that when he takes alcohol he has nausea and palpitations.

malpractice mishaps!

THE TRUSTED ALCOHOLIC

Mr. Humbleman knew all about disulfiram. He'd tried it before, and he was willing to try it again. But not today. He told the doctor he was "wound up tight" and had to have something that would relax him.

Dr. Galliet understood. He wrote an Rx for a new tranquilizer. The patient was to take a tablet three times a day, with an extra tablet permissible if he felt unusually tense. The drug came in bottles of 100 tablets, and the doctor's prescription called for this large size. But, said the label, "under no circumstances should dosage exceed four tablets in any 24-hour period."

That night Preston Humbleman began to feel sorry for himself. Rather tentatively, he composed a note. He was a failure, he wrote, a souse. His wife and daughter scorned him. Nobody loved him. He'd be better off dead.

Then he rewrote the note, put it on the kitchen table, and methodically set to work. Two tablets in the mouth. A short gulp of water. Two more tablets. Another gulp of water. In a very short time he'd downed forty-four tablets. Then he went to bed and never woke up.

Three weeks later, his widow sued Dr. Galliet for malpractice.

Our general counsel back in headquarters thought we

ought to go ahead and defend this case to the limit. But our local attorney knew the local juries. "It's well established," he said, "that there's a high suicide rate among alcoholics; and a jury might well find it negligent of a doctor to allow an alcoholic to tote home 100 lethal tablets at one time. Then, too, the jury would probably think the doctor should have warned the wife; at least he should have given *her* the opportunity to lock up the bottle."

Dr. Galliet wanted a quiet, out-of-court settlement. The plaintiff was talking in terms of $100,000, but that was for effect. In the end, we settled for $35,000—one of the biggest out-of-court settlements we've ever made.

Today Dr. Ben Galliet is sharply aware that it's not always wise to handle alcoholic patients as if they were rational, well-adjusted adults. If he'd been equally aware of it earlier, he would have saved himself and his local colleagues quite a bundle of cash in malpractice insurance premiums. END

Delinquent's Deduction

A woman patient hadn't paid my bill for months. My secretary finally sent her one of those polite little enclosures suggesting she come to the office and discuss her financial problems. The patient came—and told me such a story of misfortunes that I tore up the bill. "We'll just consider it paid in full," I said sympathetically.

"Oh, *thank* you, Doctor!" she said, dabbing her eyes. "Now, just one more thing: Will you please give me a receipt I can use for my income tax deduction?"

—E. DONALD ASSELIN, M.D.

Do Your Savings Draw Maximum Interest?

If you're salting away savings on a long-term basis and not getting at least a 3 1/2 per cent return, you may be missing more than you think

By William N. Jeffers

Are you wondering whether you're getting the most out of your savings accounts in these days of rising interest rates? If so, compare what you're now getting against what you might get in some one of the following institutions:

COMMERCIAL BANKS hold half the nation's savings accounts. But they do it on the basis of convenience—not high interest rates. A year ago, the Government raised the top limit that 6,500 Federal Reserve commercial banks could pay on savings accounts from 2½ per cent to 3 per cent. Yet most commercial banks today still pay 2½ per cent or less. And still they keep their customers.

How come? Two explanations: (1) Most depositors are short-term and/or small-amount savers, for whom the interest differential is insignificant. (2) Most deposi-

How Savings of $5,000 Will Grow

Rate of Interest	In 1 Year	In 2 Years	In 5 Years	In 10 Years	In 15 Years
2½% Compounded Annually	$5,125	$5,253	$5,657	$6,400	$7,241
2½% Compounded Semiannually	5,125	5,254	5,661	6,410	7,258
2½% Compounded Quarterly	5,126	5,255	5,663	6,415	7,266
3% Compounded Annually	5,150	5,304	5,796	6,719	7,790
3% Compounded Semiannually	5,151	5,306	5,802	6,734	7,815
3% Compounded Quarterly	5,151	5,307	5,805	6,741	7,828
3¼% Compounded Annually	5,162	5,330	5,867	6,884	8,078
3¼% Compounded Semiannually	5,163	5,333	5,874	6,902	8,109
3¼% Compounded Quarterly	5,164	5,334	5,878	6,911	8,145
3½% Compounded Annually	5,175	5,356	5,938	7,052	8,376
3½% Compounded Semiannually	5,176	5,359	5,947	7,073	8,414
3½% Compounded Quarterly	5,177	5,360	5,951	7,084	8,433
4% Compounded Annually	5,200	5,408	6,083	7,401	9,004
4% Compounded Semiannually	5,202	5,412	6,094	7,429	9,056
4% Compounded Quarterly	5,203	5,414	6,100	7,444	9,083

tors tend to save where they have their checking accounts simply because it's handier that way.

Higher Interest Rate

MUTUAL SAVINGS BANKS are harder to find but worth looking for if you want your savings to grow faster. There are 527 such banks in the U.S., most of them in the Northeast. A few now pay 3½ per cent interest on savings accounts. About sixty of them pay 3¼ per cent, and about two-thirds pay 3 per cent. The rest of the mutual savings banks still offer 2¾ per cent or even less.

SAVINGS AND LOAN ASSOCIATIONS are more numerous and more generous. Out of the 6,000 listed savings and loan associations all over the country, it's hard to find one paying under 3 per cent. Their going rate in New England is 3¼ to 3½ per cent. And a number in California and elsewhere pay 4 per cent nowadays.

Get Deposit Insurance

Some 3,700 of these associations carry a deposit insurance that backs all accounts up to $10,000. These are the ones to deal with unless you want to gamble. Uninsured associations in the Southwest offer 5½ per cent. Appropriately, some are in Las Vegas and Reno.

How can the savings and loan people pay higher interest rates than banks? Answer: Most of their funds are invested in long-term mortgages, which are bringing in respectable returns these days.

Point to Consider

Now you know how interest rates vary in general. There's one other complicating factor: the frequency with which interest is compounded.

In dollars and cents, this doesn't actually make too much difference. Suppose you deposit $10,000 at 3 per cent interest. After thirty years, you'll have $24,270 if the interest is compounded *annually;* $24,430 if it's compounded *semiannually;* and $24,510 if it's compounded *quarterly*.

But if frequency of compounding doesn't make much difference, the annual interest rate *does*. The accompanying table proves it.

For example, it indicates that if you accept 2½ per cent interest on $5,000 savings when

you could get 4 per cent, you'll be short $1,700 or $1,800 your money could otherwise have earned for you in only fifteen years.

Are *you* unnecessarily stunting the growth of your savings? Better check the going rates in your community—and outside it too. END

Who's the Expert?

When I was a very young doctor in New Mexico, I was engaged by a couple who expected their first child in about three months. I suppose they picked me because I was the only doctor handy, but I was flattered because the woman was an R.N.

I took careful pelvic measurements, looked up what they indicated in a text book, then assured the couple that there'd be no difficulties, that everything seemed normal. The woman then informed me that in an earlier pregnancy in Chicago, she'd been therapeutically aborted because of a contracted pelvis.

"Oh, really?" I said in surprise. "Who was the attending physician?"

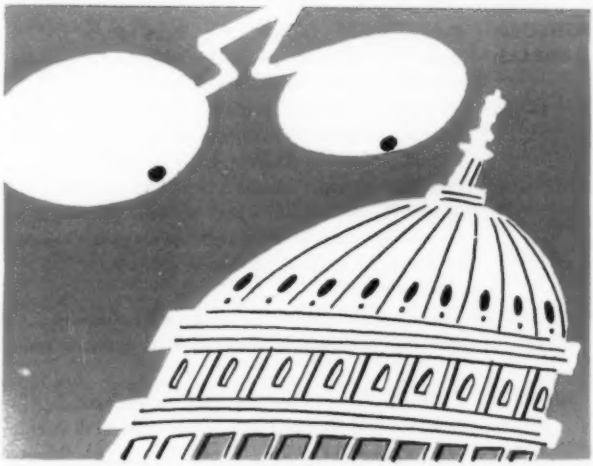
"Dr. Joseph De Lee," she answered.

Dr. Joseph De Lee! I gulped. Who was I to match my judgment against that of the famous obstetrical authority? Though my patient continued well and happy, I suffered a continuous nightmare, imagining every possible obstetrical complication and more besides.

At last the big day came. And in an arduous delivery, I delivered a normal baby boy—a feat that the illustrious Dr. De Lee had considered too difficult. I felt greatly relieved and pretty proud of myself.

At least I did until I mentioned the matter to the husband a little later. Then I learned that though the therapeutic abortion had been performed by Dr. Joseph De Lee, all right, this particular one had been merely Joe De Lee—an interne!

—JOHN D. DAVIES, M.D.



Legislation Worth Watching

Last year Congress revamped the doctor draft, voted record funds for medical research—and left eight important legislative proposals hanging. They'll be coming up for action soon. They could profoundly affect you as a physician. Use the following chart to brief yourself on their highlights and prospects

SUBJECT: Social Security for self-employed M.D.s.
BILLS: H.R. 321; H.R. 8883.
SPONSORS: Rep. Lanham* (D., Ga.); Rep. Kean (R., N. J.).
PROPOSALS: Both bills call for compulsory inclusion of self-employed physicians under Social Security.
COST: No Federal estimate available. Under the Kean bill, most self-employed physicians would be paying $306 annually in Social Security taxes by 1975.
PROSPECTS: Poor to fair. Most members of the House Ways and Means Committee—to which the bills have been referred—say there'll be no such coverage until there's evidence the medical profession wants it.
*Deceased

SUBJECT: Federally financed hospital care for the aged.
BILLS: H.R. 9467; S. 844 and H.R. 4765; H.R. 9448 et al.
SPONSORS: Rep. Forand (D., R.I.); Sen. Murray (D., Mont.) and Rep. Dingell (D., Mich.); and Rep. Roberts (D., Ala.) et al.
PROPOSALS: Forand's bill would provide up to 120 days of hospital and nursing-home care each year to all persons eligible for retirement or survivorship benefits under the Social Security Act. It would also authorize payment for in-hospital surgical services according to a Government-approved fee schedule. The other bills would provide hospitalization payments only.
COST: No Federal estimate available. But the combined Social Security tax on employers and employes would be boosted to 5 per cent on the first $6,000 of wages.
PROSPECTS: Poor to fair. The Forand bill has strong support from the A.F.L.-C.I.O. and some liberal Congressmen, but not much other backing at present. The A.M.A. has formed a special committee to fight it.

SUBJECT: Tax deferment for the self-employed.

BILLS: S. 831, H.R. 9, H.R. 10 et al.; H.R. 45 et al.

SPONSORS: Sen. Dirksen (R., Ill.), Rep. Jenkins (R., Ohio), Rep. Keogh (D., N. Y.) et al.; Rep. Coudert (R., N. Y.) et al.

PROPOSALS: The Dirksen-Jenkins-Keogh bills would permit the self-employed to put as much as $5,000 a year into privately managed retirement funds—such funds to be exempt from income tax until drawn out after retirement. The Coudert bill would permit both self-employed and employes to put aside $3,000 annually in similar fashion.

COST: No direct Federal cost. Indirect tax loss estimated at around $400,000,000 a year.

PROSPECTS: Fair. Professional groups support such tax deferment. So do a majority of Congressmen, according to one poll. But many in Congress are against it as long as self-employed M.D.s remain outside the Social Security system.

SUBJECT: Federal aid for medical schools.

BILLS: S. 1917, H.R. 6874 et al.; and S. 1922, H.R. 7841.

SPONSORS: Sen. Smith (R., N. J.) et al. and Rep. Harris (D., Ark.) et al.; Sen. Hill (D., Ala.) et al. and Rep. Fogarty (D., R.I.).

PROPOSALS: The Smith-Harris bills would authorize Federal grants to medical schools covering up to half their new construction costs. The Hill-Fogarty bills would provide up to two-thirds of such costs.

COST: $195,000,000 to $260,000,000 over a five-year period.

PROSPECTS: Fair to good. Both the Administration and the A.M.A. have backed the idea. But stepped-up defense expenditures may leave no room for this program in the national budget.

SUBJECT: Non-service-connected cases in V.A. hospitals.
BILLS: H.R. 58.
SPONSORS: Rep. Teague (D., Tex.).
PROPOSALS: Veterans with non-service-connected disabilities would be required to list health insurance and other assets before being hospitalized at Government expense. If found able to pay for private care, they'd be refused admission.
COST: No direct Federal cost. If the proposed law were fully enforced, the V.A. would lose $3,000,000 annually now collected from health insurance carriers in such cases.
PROSPECTS: Poor. Many Congressmen feel that recently revised V.A. regulations now make such legislation unnecessary.

SUBJECT: Tax deductions for medical expenses.
BILLS: H.R. 129; H.R. 8253; H.R. 3268 et al.
SPONSORS: Rep. Curtis (R., Mo.); Rep. Wharton (R., N.Y.); Rep. Whitten (D., Miss.) et al.
PROPOSALS: These bills would liberalize the Federal income tax law, which at present permits taxpayers to deduct medical expenses in excess of 3 per cent of their taxable incomes, up to a $10,000 maximum. The Curtis-Wharton bills would take off the $10,000 ceiling. The Whitten bill would authorize taxpayers to deduct *any* medical expenses not covered by health insurance or otherwise compensated for.
COST: No Federal estimate available.
PROSPECTS: Poor to fair. Congress brought the base percentage down from 5 to 3 per cent only a few years ago. Insiders don't expect further liberalization in the near future.

SUBJECT: Health insurance pooling.
BILLS: S. 1750; H.R. 489 et al.
SPONSORS: Sen. Hill (D., Ala.) and Sen. Smith (R., N.J.); Rep. Thompson (D., N.J.) et al.
PROPOSALS: These are redrafts of earlier Administration-backed bills that would have authorized Federal reinsurance of health plans. Instead of setting up a Government reinsurance fund, the new bills would permit small insurers and the Blue plans to pool some of their assets to protect themselves against loss while experimenting with new types of coverage.
COST: No cost to the Government.
PROSPECTS: Poor. The Administration backs the idea, but nobody else seems much interested—not even insurance carriers.

SUBJECT: Health insurance for Federal workers.
BILLS: S. 2339 et al.; H.R. 7034 et al.
SPONSORS: Sen. Johnston (D., S.C.) and Sen Carlson (R., Kan.) et al.; Rep. Holifield (D., Calif.) et al.
PROPOSALS: Some 4,500,000 Federal civilian workers and their dependents would be provided with both basic and major medical coverage. They'd choose their own basic plans; the Government would contract for the major medical. They'd pay their own way, assisted by Federal contributions of up to $58.50 per employe per year.
COST: An estimated $64,500,000 annually.
PROSPECTS: Fair to good. The Administration backs the Senate bill, and there's apparently no major opposition to its basic features. The national budget is the main potential stumbling block that the bills' sponsors will have to overcome.

END

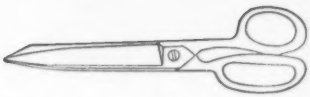
Your 1958 Tax

January 15 PAY the balance of your estimated Federal income tax for 1957. ATTENTION: *Will this fourth installment bring the total estimated tax paid to within 70 per cent of the actual tax due?* If not, you may have to file an amended estimate in order to avoid penalty. (NOTE: This Jan. 15 installment may be omitted if you plan to file your final 1957 Federal income tax return by Jan. 31.)

January 31 PAY the income taxes and Social Security taxes withheld from your employes' salaries during the last quarter of 1957, plus your own Social Security contributions as their employer. FILE (a) Form 941 listing the above amounts; (b) Forms W-2 (one for each employe); (c) Form W-3. (NOTE: If you had four or more employes during 1957, also pay the Federal unemployment tax and file Form 940.) ATTENTION: *Did you file your Jan. 15 installment of estimated Federal income tax?* If not, you must file your final return for 1957 and pay the balance due.

April 15 PAY your final Federal income tax for 1957, if you haven't done so already. FILE Form 1040. PAY one-fourth of your estimated Federal income tax for 1958. FILE Form 1040-ES.

April 30 PAY the income taxes and Social Security taxes withheld from your employes' salaries during the first quarter of 1958, plus your own Social Security contributions as their employer. FILE Form 941.



Cut along dotted lines and clip to the proper pages of your daily calendar

Tax Calendar

June 15* PAY the second quarterly installment of your estimated Federal income tax for 1958. ATTENTION: *Make sure that the sum of your first and second installments equals or exceeds 50 per cent of your total estimated tax for 1958.* If necessary, file an amended declaration.

June 30 FILE a renewal application for your Federal narcotic tax stamp. Include an inventory of the narcotics you presently have on hand.

July 31 PAY the income taxes and Social Security taxes withheld from your employes' salaries during the second quarter of 1958, plus your own Social Security contributions as their employer. FILE Form 941.

September 15 PAY the third quarterly installment of your estimated Federal income tax for 1958. ATTENTION: *Make sure that the sum of your first, second, and third installments equals or exceeds 75 per cent of your total estimated tax for 1958.* If necessary, file an amended declaration.

October 31 PAY the income taxes and Social Security taxes withheld from your employes' salaries during the third quarter of 1958, plus your own Social Security contributions as their employer. FILE Form 941.

*Since this date falls on a Sunday, the required payment may be mailed the following day.

END

What Physicians Want From Blue Shield

Are they satisfied with its basic principles? Not entirely, according to this state-wide survey

By Hugh C. Sherwood

Would you like to see some fundamental changes in the principles on which your Blue Shield plan operates? If so, you're not alone: A recent survey indicates that doctors are by no means unanimously sold on the basic tenets of Blue Shield.

The Michigan State Medical Society has sounded out some 2,500 of Michigan's 6,300 doctors on almost every aspect of the state's plan. Obviously, the findings reflect attitudes within that state. But they're probably an indication of what doctors in other areas are thinking too. Reason: Michigan has long been considered a bellwether state for the Blue plans.

What's more, Blue Shield in Michigan has been under growing pressure from local labor unions. So the state's medical men have been forced to re-examine their own

---

THIS ARTICLE *analyzes some of the findings in a recent Michigan study of doctors' attitudes toward Blue Shield. It's the first of three on the subject.*

health insurance plan with a critical eye. Their conclusions may not be yours. But you'll find that they're worth pondering.

Not that the doctors are uniformly dissatisfied with Blue Shield. To the contrary: The survey reveals that "by far the majority of doctors in private practice want and need Blue Shield, believe in its policies, abide by its principles, and are satisfied with its administration," reports the medical society.

But many of the respondents are evidently ready for changes—and some astonishing ones at that. Consider the very fundamentals:

Like most Blue Shield plans, Michigan Medical Service has long adhered to four basic tenets: (1) It provides full service benefits. (2) It offers such benefits only to subscribers below certain income levels. (3) It pays doctors according to a fixed fee schedule. (4) It charges subscribers a so-called "community rate"; that is, it

charges all subscribers alike instead of varying the premium rate according to their ages, occupations, or the degree to which they utilize the plan's benefits.

Those tenets might seem so firmly established as to be sacrosanct. But they're not. Though the surveyed doctors still go along with the principles of service benefits and income ceilings, many of them seem to have turned against the concepts of fixed fee schedules and community rating. Let's look more closely at the Michigan findings:

The surveyed doctors' opinions are presented in the tables that follow and are analyzed in the accompanying text. For the sake of simplicity, a number of allied questions have been omitted; the wording of those that have been tabulated has been condensed. And all percentages have been rounded off.

Should Blue Shield Be a Service Or an Indemnity Plan?

A service plan	41%
An indemnity plan	16
No opinion	43

It's no surprise that a good portion of the Michigan doctors support a service plan. It *is* a surprise that the largest portion don't feel very strongly one way or the other. The physicians give further evidence of their mixed feelings about this in the answers they make to two other questions:

Better than four out of five say they'd like Blue Shield to extend service benefits to middle-income groups. And the same whopping majority would like Blue Shield also to offer new indemnity policies requiring co-insurance and deductibles.

What their answers seem to add up to is this: Doctors still like the idea of offering service benefits to certain groups. But they also like the idea of offering a greater variety of health insurance arrangements than Blue Shield has made available heretofore.

Should Income Limits for Full Service Benefits Be Raised Above $5,000?

Raised—provided fees are, too	59%
Kept at the same level	32
Raised—with fees unchanged	7
Lowered—with fees lowered, too	2

Blue Shield plans originally offered full service benefits to low-income groups only. But by raising their income ceilings, many plans have extended such coverage to middle-income groups. Other Blue plans are seriously considering following in their footsteps. Such extensions are apparently supported by a majority of the doctors surveyed.

In answer to an allied question, better than 68 per cent say they'd like their plan to offer full service benefits to persons with annual incomes of up to $7,500. But their answers to all such questions indicate that if ceilings are raised, most physicians would expect their fees to be raised too.

Should Blue Shield Fees Be Raised?

Yes—on a selective basis	64%
Yes—across the board	23
No—they're reasonable now	13

As the survey report puts it: "The doctors' chief gripe at Blue Shield is 'inequities' in the schedule of payments they receive for services. They say the fee schedule hasn't

kept pace with the changing science of medicine nor the rising cost of living."

Higher fees would help—and so would something else, the Michigan M.D.s feel: Over two-thirds of the surveyed men would like to see Blue Shield fees tied to the cost of living.

Actually, almost half the respondents would prefer having no such thing as "Blue Shield fees." They'd prefer having Blue Shield pay the doctors' *usual* or *average* fees, checking them if necessary against relative value scales adopted by county medical societies. Doctors who felt this way were in the minority—but just barely. These doctors are apparently fed up with the whole idea of fixed fee schedules.

Should Blue Shield Develop a Variable Premium System?

Yes	55%
No	45

What would happen if the principle of charging all subscribers at the same rate were junked in Michigan or anywhere else? The nonprofit plans could then compete more effectively with commercial carriers. They'd be able to charge business firms with low utilization rates less than some other segments of the community which have a higher utilization rate. As a result they would very likely stop losing big, blue-chip accounts. This is probably what the majority of the surveyed doctors had in mind.

The minority's attitude might be summed up this way: If Blue Shield charged some subscribers less, it would have to charge others more. In so doing, it could no longer carry out its original function of serving persons in low-

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by A. Lewin-Funke

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income brackets. This would undermine Blue Shield's status as a bulwark against the kind of government intervention that can come when too many people get too little medical care.

This division of opinion isn't conclusive. Like some of the other survey findings, it must be regarded as a straw in the wind—and the Michigan doctors know they've got to pursue their study further. Nearly 60 per cent of them say they're willing to have their medical society dues upped, if that should prove necessary, in order to support further research into the direction that Blue Shield should take. END

"Who said that?"

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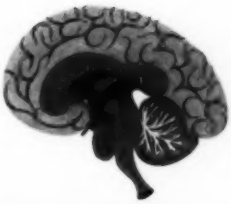

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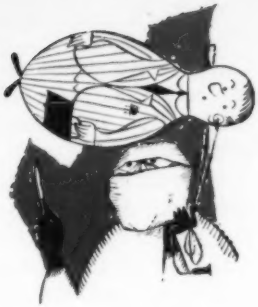

Medicine's Worst Sin

Its name is greed. It isn't a limited specialty. In fact, it shows up most often in the unlimited surgery attempted by some G.P.s, says this surgeon

By Charles Thurd, M.D.

Just about a year ago, the late Dr. Francis T. Hodges told MEDICAL ECONOMICS readers what he thought were "Medicine's Seven Deadly Sins." Perhaps the worst of these, he asserted, was *greed.*

I agree.

And, like Dr. Hodges, I believe it's an evil that knows no boundaries of practice.

There *are* doctors who seem to take a narrower view. For example, Dr. Julian B. Cole, past president of the Kentucky Academy of General Practice, was quoted in a recent issue of MEDICAL ECONOMICS as leveling the accu-

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THE AUTHOR, *who writes here under a pen name, was the first board-certified surgeon in a good-sized Midwestern city.*

sation of greed at a single segment of the profession: the specialists.

Who's throttling the feeling of brotherhood in medicine? Dr. Cole believes it's the type of specialist who feels a "great concern . . . for the patient [and] wants [him] to have the best. In other words, the specialist . . ."

Cole's Target

Dr. Cole's choler is directed primarily against the obstetricians and gynecologists in one Kentucky city. Their crime: an attempt to deny hospital delivery-room privileges to G.P.s. "They [say they] are doing all this to protect the patients," comments the doctor. "Everyone there who has seen the shenanegans that have been pulled thinks it the greatest display of GREED ever witnessed . . . I am almost nauseated by the asinine ego of this specialty group. The Kentucky Academy of General Practice is making great strides to prevent this type of robbery."

Shenanegans? Robbery? Those are strong words. By implication Dr. Cole would have us believe that such vices are restricted subspecialties of the specialist.

It's a vivid picture he paints. But before the paint is dry, I'd like to add a few brush-strokes of my own.

What are my qualifications for doing this? Well, after graduating from a large state medical school in 1928, I was awarded a five-year teaching fellowship in surgery. With borrowed money and the income from my wife's job, we were barely able to exist while I trained as a specialist in general surgery.

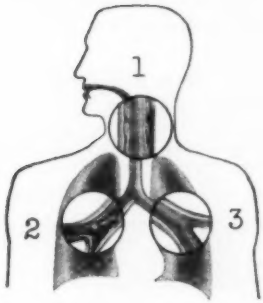
On finishing training, I opened an office in my present city. Here I found many of my medical school classmates who were already full-fledged G.P.s. They had well-established practices and good incomes. They had children, homes, cars, even bank directorates. They'd been granted full privileges in one or more of the city's hospitals.

Temptation Overcome

Seeing how well they were getting on, I was tempted to augment my meager starting income with a bit of general practice. But I didn't. Instead, I limited myself to the specialty for which I'd qualified by five years of training.

In the hospital of my affilia-

breaks up cough*



*Drawing shows how 3-pronged attack of Pyribenzamine Expectorant with Ephedrine breaks up cough by: (1) reducing histamine-induced congestion and irritation throughout the respiratory tract; (2) liquefying thick and tenacious mucus; (3) relaxing bronchioles. Pyribenzamine Expectorant with Codeine and Ephedrine also available (exempt narcotic). Pyribenzamine® citrate (tripelennamine citrate CIBA). **C I B A** Summit, N. J.

tion I was supervised by a Surgical Rating Board. This consisted of one of my G.P.-classmates and several older G.P.s who were "surgeons by assertion." Supervising me appeared to be a fine way for them to pick up recent surgical techniques at no cost. Finally, after a few years of "protecting the public and hospital" from the results of my training, they graciously granted me full surgical privileges in the hospital.

In the years since, a number of other full-time specialists have come to my city. Like myself, most of them have limited their practices. But many of our G.P. colleagues are more ambitious. They find the restrictions of general practice too confining. And without training for a specialty, they've decided to be specialists.

Here's What Happens

I give you a few true examples of incidents that have happened as a result:

Example #1: Dr. R. has had no training in surgery. It's his delight to rib us surgeons by asserting that "any fool can take out an appendix." On one par-

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ticular afternoon he apparently decided to prove it. He invaded the surgery and the abdominal cavity of his trusting patient with equal confidence. But after a two-hour search he failed to locate his objective, the patient's appendix.

Was he upset? Not noticeably. He was apparently convinced he'd found a medical curiosity of monumental import: a patient with a congenital absence of appendix! In his mind he was perhaps already phrasing a case report for the journals. But just for the sake of form, he asked a

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surgeon to confirm his discovery.

The surgeon, following the precise procedure that results from years of training, located and delivered the elusive appendix. For this he was sincerely thanked by Dr. R. And Dr. R.—who will always be The Great Surgeon to that lucky patient—pocketed a respectable fee. What's more, he still schedules appendectomies.

Ready to Operate

Example #2: From time to time, Dr. B. used to assist in surgical repair of various types of hernia. Then one day he attempted surgical relief of what he labeled an "incarcerated hernia."

His surgical exposure revealed a bowel of questionable viability. Somehow he realized that his experience and judgment weren't quite up to handling it properly. And since he knew he couldn't perform resection and anastomosis of the bowel if it should be necessary, he decided to call for the full-time surgeon. The latter completed the procedure.

Don't think Dr. B. wasn't grateful. His thanks to the surgeon were warm and profuse. But did the G.P. collect and retain the fee for the operation? And did he accept credit from the patient for being skilled with a scalpel? You bet he did.

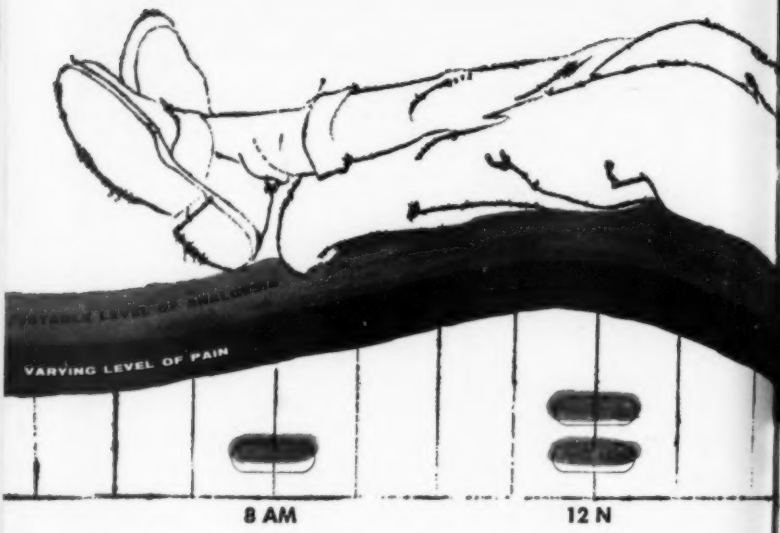
Example #3: Another G.P. who thinks he's missed his metier is Dr. J. If you doubt it, consider the neat hemorrhoidectomy he performed one morning. Only trouble was, he was roused by a phone call at 2 A.M. the following day: His patient had been found in shock, presumably from concealed hemorrhage.

Dr. J. rushed to the hospital. But he couldn't find a source of hemorrhage. Urgently, he called the specialist. "Wonder if you'd mind hopping down here and giving me a hand, old boy?" he asked.

Old Boy arrived, did an anal examination, confirmed the probable source of bleeding, and took the patient to surgery. There he located the unligated bleeding vessel overlooked by Dr. J. After which, he wearily went home to bed.

Surgical Fiasco

Example #4: Dr. S. also believes that surgeons are born, not trained. His demonstration of this theory once completely dis-



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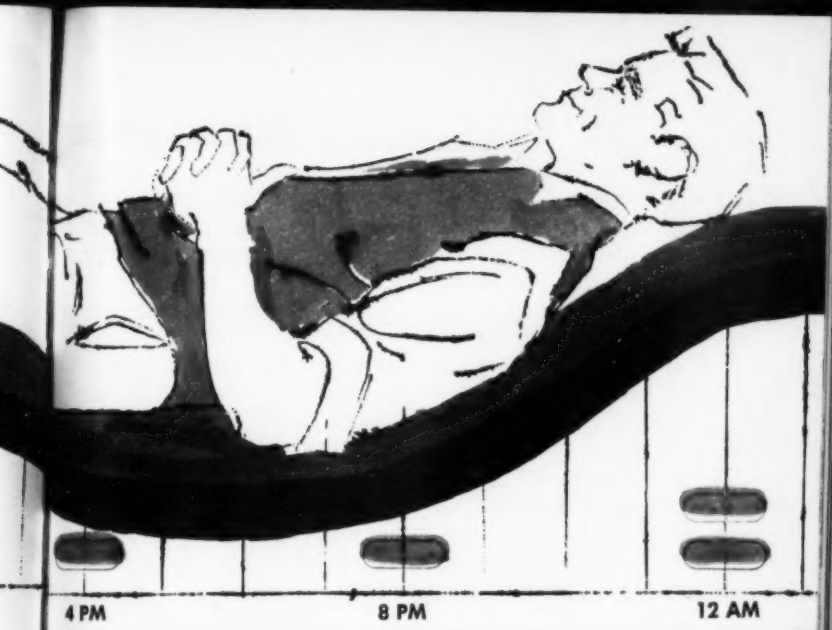

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Each capsule contains:

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Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Phenaphen No. 2

Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

For moderate to severe pain

Phenaphen No. 3

Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

For severe or stubborn pain

Phenaphen No. 4

Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

For stubborn or intense pain—to obviate or postpone use of morphine or addicting synthetic narcotics

DOSAGE: One or two capsules as required.

rupted an operating room schedule: For three-and-a-half hours, he tried to repair a large ventral abdominal hernia.

He couldn't free the adherent bowel from the hernial sac. He seriously damaged the blood supply to several portions of the bowel. And he perforated the bowel in several places—which naturally contaminated the entire operating field. Finally, he called for help.

As it happened, the surgeon wasn't in the operating suite that day. He was in his office, tending to his strictly limited practice. But now he was forced to protect the vulnerable patient and the hospital from the ineptness of Dr. S. He canceled the rest of his appointments and hurried to the hospital.

Thanks, But No Fee

As the result of his sure hand, the patient was patched up and the hospital protected. Dr. S. "saved face"—and charged a good fee. The specialist got thanks but no money.

I think these four cases from my own experience speak for themselves. Surely the doctors

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LAKESIDE

I've told you about ought to be aware of their limitations. Certainly they ought to know they lack specialized training. Why do they risk their patients' lives by attempting procedures for which they're not qualified?

Primarily, I'm afraid, to make money. Is there a prettier name for this sort of thing than *greed?*

When Patients Needle You

By Theodore Kamholtz, M.D.

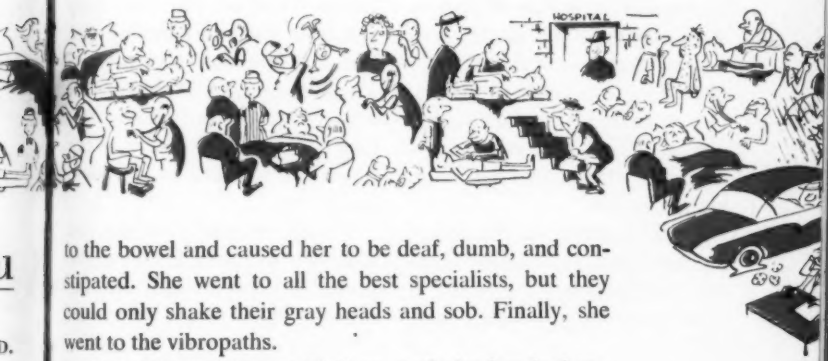
Needling the doctor is an art practiced by many patients on many planes. Think of the number of times, for example, you've encountered some variation of the I-Dare-You-to-Explain-This Technique:

An exponent of this method tells the doctor about a case he "knows personally." He never actually does know the case personally, nor does he know the particulars any too well. So, as he goes along, he adds picturesque details to give an air of verisimilitude to an otherwise unconvincing story. It comes out something like this:

He has a cousin who had cancer of the brain. It spread

Mind you, I'm not contending that *all* G.P.s are greedy. Most of them aren't. Neither are most specialists.

Nevertheless, greed has no place in the profession of medicine. That's why it's up to *all* of us to do battle against it—even within our own field of practice, if it turns up there. END



to the bowel and caused her to be deaf, dumb, and constipated. She went to all the best specialists, but they could only shake their gray heads and sob. Finally, she went to the vibropaths.

They adjusted her oscillations, and she has had natural movements ever since. Now, Doctor, explain how the specialists . . . explain how the vibropaths . . .

And what about the aunt of his business partner? She had an ingrown toenail. She was admitted to the hospital and operated on. The surgeon left a hemostat, a towel, and a doorknob in the wound. When she got to her room, the nurse placed her on a bread-and-water diet for six days because she complained about having her head shaved.

Finally, she was mistaken for a patient who was due to be admitted the following week for an emergency hemorrhoidectomy. Now, Doctor, please explain how, in this

day and age, any hospital can . . .

The doctor is left with only three answering gambits. He can grunt—which is interpreted as a sign he's unable to accept the challenge. He can venture an opinion that his heckler is slightly misinformed—but this is construed as evidence that professional ethics makes all doctors stick together, no matter how flagrant the error. Or he can go into a long discussion of the history of medicine, the philosophy of illness, and psychotherapy—all in an attempt to wear down his antagonist.

Futile attempt. At the end of his discourse, the patient chortles triumphantly: "So there *is* some good to vibropaths after all!"

Another form of not-so-subtle needling consists of milking a visit dry and getting the most for the fee. This method might be termed The Squeeze.

The doctor is called out to see little Wilbur, who has a fever of 103. After he has written out his prescription, the mother asks him if he'd mind—that is, as long as he's already there—taking a quick look at little Herman's stuffed ears.

And Dora. And Dora's cousin from the country. And Father, who has his rheumatics. And then—if it's not too much trouble, of course—Mother herself has a little heartburn.

And, Doctor, the dog has worms.

So much for the extensive variety. The intensive variety occurs in the office. The obese lady has been given a reducing diet and the attendant instructions. The fun begins when she asks for a check-up on her blood pressure—then on the tickle in her throat, on the ache in her back, and so on.

Finally, as she's leaving, she tells you she was once on the prescribed diet before, but she didn't lose a pound. Anyway, she'd get so hungry she'd have to take a sandwich and a malted between meals to keep from passing out.

Even some people who think themselves above doctor-baiting consider the maxim "Physician, Heal Thyself" the acme of humor. The unfortunate professional who submits to his yearly bout of hay fever is depressed not only by the teary ravages of the disease, but by the inevitable clever, humorous remarks that accompany it.

MORE▶

first thought for high b.p.*

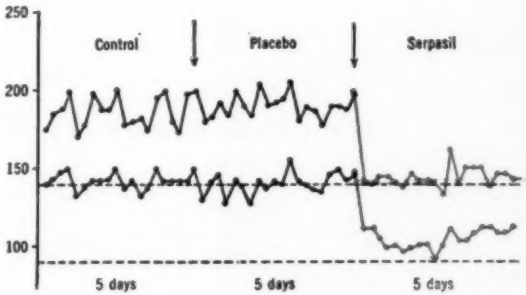


*Chart shows actual response to Serpasil in a patient with benign essential hypertension (data on request). Consider Serpasil® (reserpine CIBA) (1) alone to lower blood pressure gradually and safely in most cases of mild to moderate hypertension; (2) as a primer in severe hypertension before more potent drugs are introduced; (3) as a background agent in all grades of hypertension to permit lower dosage and thus minimize side effects of other antihypertensives. **C I B A**

From the first sneeze on arising to the last wipe of the nostril before going to bed, he's gleefully chided for having let *this* happen to *him*. Even his colleagues —who should know better— can't resist the crack wise.

A doctor can also be needled on the basis of his specialty. There's open season on psychiatrists throughout the year. One has only to be able to pronounce some of the syllables in order to state, for general consumption, that psychiatrists are crazy. This is also one field of medicine in which people are able, in words of eleven syllables, to state the most appalling misconceptions.

It's useless to argue that anyone meeting a psychiatrist is probably unconsciously on the defensive, afraid he may be analyzed against his will. The long and short of it is that everyone thinks himself a psychiatrist.

The types of doctor-baiting are many, the applications frequent. Everything considered, it's amazing how unmoved all this needling leaves the average M.D. The reason for his equanimity? He knows it's he who wields the last needle. END

Come Back When You're Well

I'd recently joined a clinic group. While waiting for my specialty practice to build up, I was helping out with the clinic's program of pre-employment physical exams for a large company. One afternoon I entered my office to find a pretty girl sitting on the table in an examination gown. I asked her a few pre-employment health questions. She replied she hadn't been feeling well and thought she might have Asian flu.

Not wanting to hurt her chances for employment, I said: "Why don't you go home and come back to see me when you're feeling better?"

She looked astonished. I understood why when I found out she was no job candidate, but was there to have a stomach ailment diagnosed. —WILLIAM H. KEENER, M.D.

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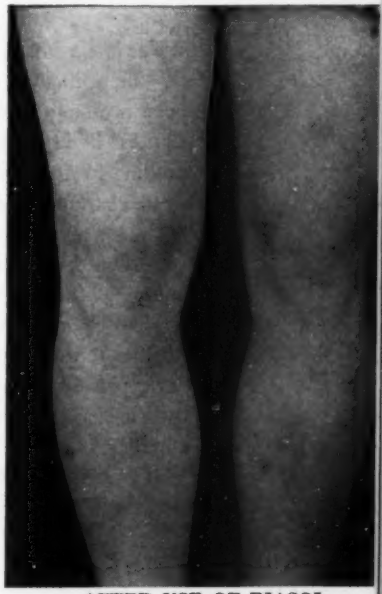

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RIASOL FOR PSORIASIS

'Start Treating PEOPLE— Not Complaints'

That's what experienced doctors tell their colleagues. Here are tips on how to provide complete care rather than merely stop-gap aid

By John E. Eichenlaub, M.D.

It was just a casual question at a medical class reunion—but the young doctor answered it seriously. "What has been my main accomplishment?" he mused. "Just this, I guess: I've spotted nine different malignancies that had nothing to do with the ailment that brought the patient to me. I found cancer in the left breast in a woman with a sore leg . . . cancer of the rectum in a man with varicose veins . . . cancer of the skin in a fellow with a sprained ankle . . . and so on."

He'd been able to make those nine diagnoses because he does thorough physical exams as a matter of routine. "I've proved to my own satisfaction," he added, "that over-all care is better medicine than complaint-centered care."

It's also far more efficient. Says a G.P.-neighbor of mine with an enormous practice:

"I could never handle my patient load if it weren't for one thing: Almost every patient I see has already had a complete examination. In my early years, I built complete records on most of the people I'm seeing today. Otherwise I wouldn't be able to take good care of them now."

This same doctor makes another point: "Patients may fight complete check-ups at first. They're often scared to death of what I might find. But once I finish a thorough job, they thank me for taking so much interest in them. And they come back the next time they get sick."

So there you have three good reasons for treating the whole person rather than the specific ailment: Over-all care is better medicine, it's more efficient, and it helps build your practice.

But how can you win over the patient who rebels at the idea of a complete check-up?

Well, some experienced doctors have their aides handle this problem. I know of one man, for instance, whose new patients routinely get an hour-long morning appointment. The receptionist will arrange a brief afternoon visit too, if the patient's complaint seems to demand

immediate attention. But she points out that the longer visit routinely comes first.

"The doctor feels that a thorough check-up lets him do better work for you," she explains. "For his sake and yours, he wants to know all about you right from the start. That way, he's more able to understand why one part of you isn't working right."

Perhaps you'd prefer to wait till the end of your patient's first visit before bringing up the question of over-all examination. My partner has a good way of doing this: He treats all complaint-centered care as a stop-gap—and tells the patient so.

"There, that will hold you till we can work in a complete examination," he'll say. "You'll be due for another visit next week. Tell Miss Emerson to schedule you for a full-hour appointment, if you like, and we'll cover all the angles."

For Old Patients Too

What about the patient who has slipped into an established relationship with his doctor without ever having a complete examination? Some medical men believe that your best chance to propose thorough review to such a patient may come when his response to treatment seems a bit slow.

"You're making progress," you might say. "But I wonder whether anything is holding you back a little. Why not let me check you over from head to toe? Maybe we can speed your recovery."

They Don't Know How

Most patients not only *need* a personal physician, they actively *want* one. And the personal physician is the man who treats the person, not the person's complaint. The trouble with many doctor-seeking laymen is that they simply don't know how to get on the proper basis.

"I just put it to them straight," says one very successful G.P. "I say: 'If you'd like me to be your family doctor, I'd be delighted. But in that case I think we should start things off with a thorough check-up. Then I'll be ready to help with anything that ails you.' "

Patients Like It

How do his patients react? "They seldom reject the idea," says the doctor. "You know, I've

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BIBLIOGRAPHY: Baer, J. E. *et al.*: *Fed. Proc.* **16**:278, (March) 1957; Beyer, K. H. *et al.*: *Fed. Proc.* **16**:282, (March) 1957; Ford, R. V. *et al.*: *M. Rec. & Ann.* **51**:376, (April) 1957; Ford, R. V. *et al.*: *Arch. Int. Med.* **100**:582, (October) 1957; Ford, R. V. *et al.*: *Antibiotic Med. & Clin. Therapy* (in press); Moyer, J. H. *et al.*: *Proc. Soc. Exper. Biol. & Med.* **95**:529, (July) 1957; Novello, F. C. and Sprague, J. M.: *J. Am. Chem. Soc.* **79**:2028, (April 20) 1957; Russo, H. F. *et al.*: *Fed. Proc.* **16**:333, (March) 1957; Hollander, W. and Wilkins, R. W.: *Boston Med. Quart.* **8**:69, (Sept.) 1957; Freis, E. D. *et al.*: *J.A.M.A.* (in press); Finnerty, F. A.: *N. Y. State J. Med.* **57**:2957, (Sept. 15) 1957; Freis, E. D. and Wilson, I. M.: *Med. Ann. District of Columbia* **26**:468, (Sept.) 1957; Freis, E. D. *et al.*: *Circulation* (in press).

read that only a minority of the population have a family doctor whom they've seen in the past five years. I'm sure a big majority *want* one. When you suggest the idea, almost everybody leaps at it."

It's Up to You

So the physician who brings his patients around to complete care instead of complaint-centered treatment is following the straightest possible professional path. And somebody has to establish the total-care concept in each patient's mind. Why shouldn't it be you? END

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References: 1. Martin, G. J.: Ion-Exchange and Adsorptive Agents in Medicine, Little, Brown and Co., Boston, 1955, P. 205. 2. Lichtman, A. L.: Exper. Med. & Surg. 9:90, 1951. 3. Gabroy, H. K., and Selsman, G. J. V.: Amer. J. Digest. Dis. 20:395, 1953.

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Buying Property? Beware These Traps!

A lawyer red-flags them for you—and outlines the steps you should take to protect your investment

By Palmer W. Everts, LL.B.

If you're planning to buy a home, office building, or lot, your lawyer will help guard you from legal and financial woes. But you can also help yourself by watching out for potential trouble spots. Here are the five most common legal traps—with some suggestions on how to bypass them:

1. *Restrictions and zoning ordinances.* Imagine the surprise of a Missouri physician when a neighbor objected to his seeing patients in his home. Surprise turned to consternation when the doctor was haled into court and ordered to cease and desist. It seems the original developer of the land had put certain restrictions into the

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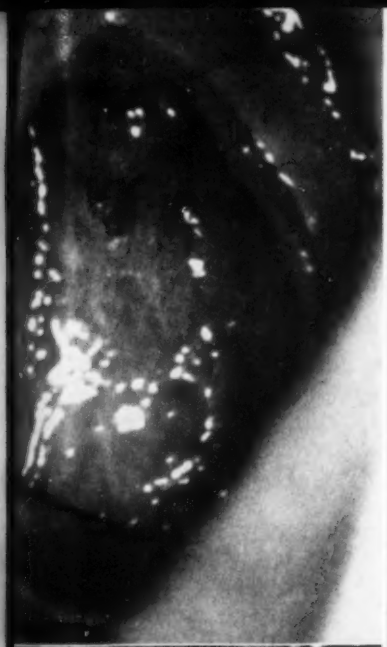
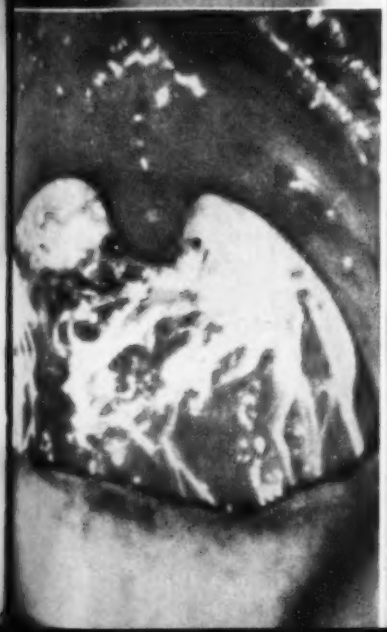
THE AUTHOR *is executive secretary of the New York State Title Association.*





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parcel deeds. One of these stipulated that the lots were for residence only—no "trade or business of any kind." The court interpreted this restriction as excluding the practice of medicine. Other courts have ruled similarly.

Zoning ordinances (restrictions set up by municipal authorities) can tie your hands, too. In many neighborhoods, an M.D. is allowed to practice at home only if his office is an integral part of the house. In others, no doctor can bring a patient into his home except socially.

Visit City Hall

Such limitations won't bother you if you don't intend to practice on the property you're buying. But you'll do well to examine the seller's deed for *other* restrictions. It's also a good idea to check local zoning regulations at the office of the municipal planning board.

And don't forget that it works both ways: The *absence* of zoning laws can be dangerous in some situations. For example, consider the Southern surgeon who bought a house in a section that had never been zoned for exclusive residential use. Soon after he moved in, a small foundry was erected on the land adjoining his. The night shift's hammering forced him to sell his property at a great loss.

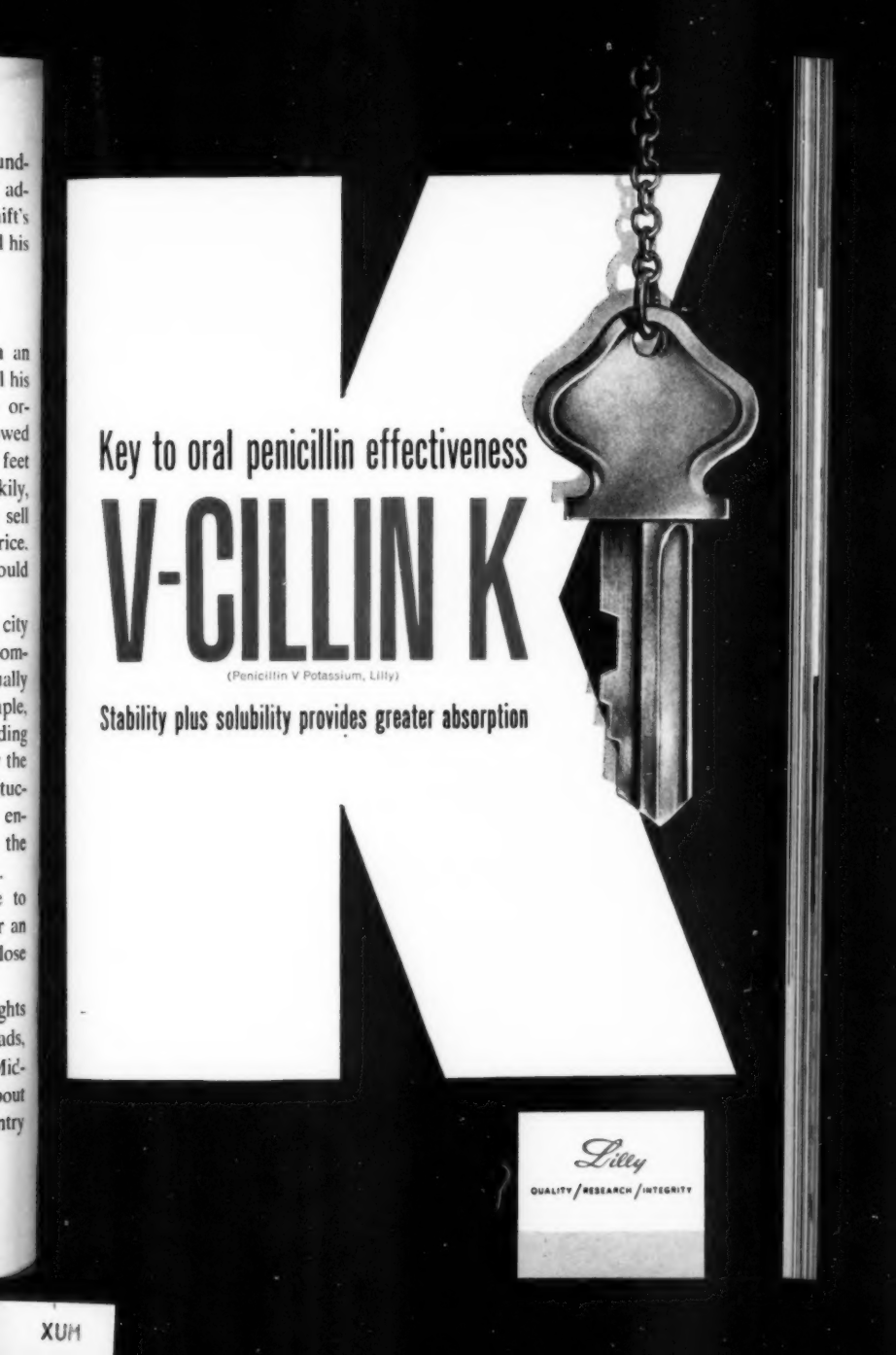
Revealing Survey

2. *Encroachments.* When an Ohio practitioner tried to sell his house, a prospective buyer ordered a new survey. It showed that the house extended five feet onto a neighbor's land. Luckily, the neighbor was willing to sell the ground at a reasonable price. Otherwise, the doctor would have been in the soup.

Small encroachments on city streets are perhaps more common. And they can be equally costly. Suppose, for example, you're buying an old building that has been modernized by the addition of a new stone or stucco front. If the addition encroaches on city property, the city can demand its removal.

It's much less expensive to have a new survey made (or an old one redated) *before* you close the deal.

3. *Easements.* These are rights of way across land for roads, drains, power lines, etc. A Midwestern G.P. found out about them when he bought a country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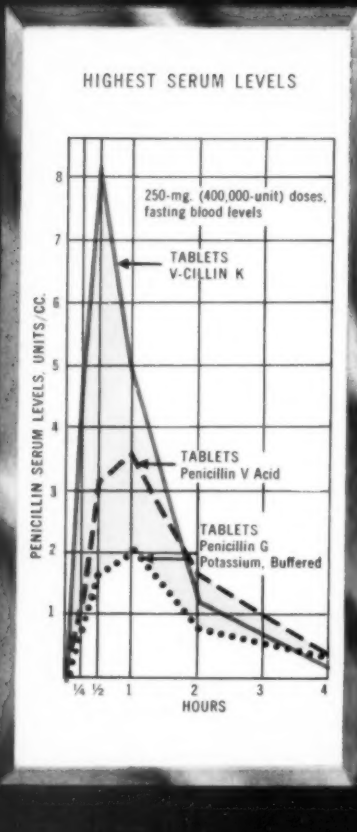

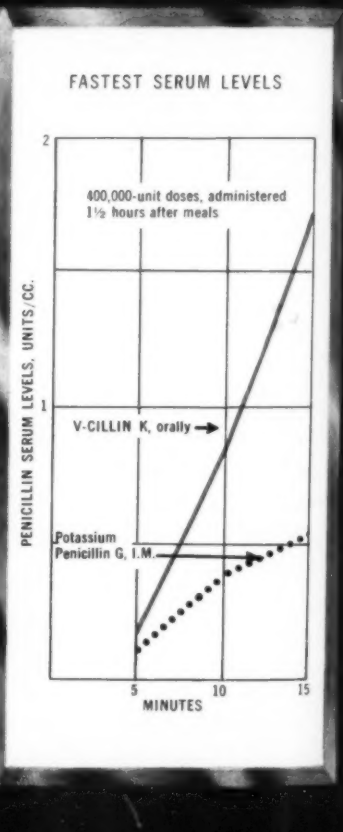

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lot, intending to put up a new home. He paid no attention to a deeply rutted trail across his land —until he was served with an injunction barring construction of the house. And there was nothing he could do about it. Here's why:

A neighbor of the former owner had frequently driven his car over the trail to save a two-mile trip to the main road. This practice, continued over a great many years, had established an easement for the neighbor. And he wouldn't sell his legal right of way at any price.

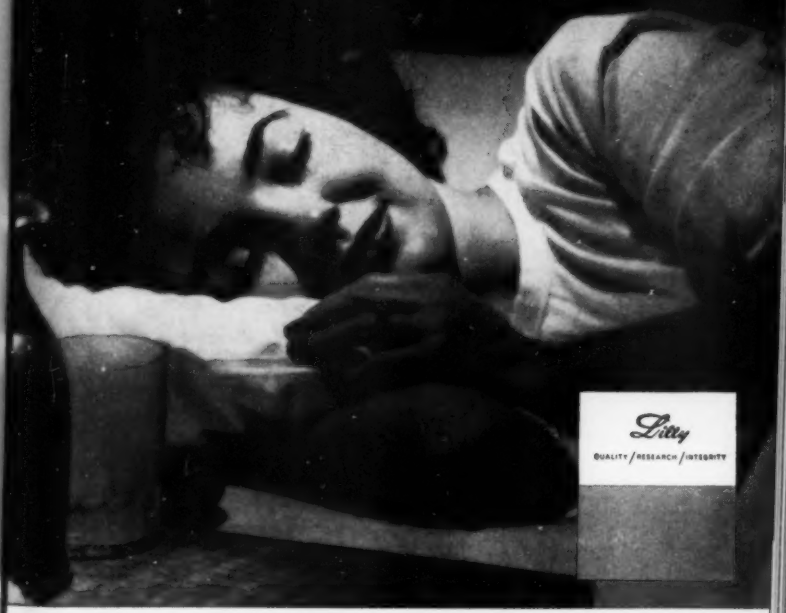
How could the former owner have prevented the trail from becoming an easement? He could have blocked it off periodically. Or he could have charged the neighbor a nominal $1 a year for its use. Or he could have given him a revocable written permit. But since he hadn't taken any of these steps, the neighbor had automatically acquired a legal right to the trail. What's more, the lack of a recorded written agreement prevented the doctor's lawyer from finding out about it when he searched the public records.

MORE▶

Before You Buy That Property . . .

- ✓ Check on local restrictions and zoning laws.
- ✓ Have your lawyer O.K. the preliminary contract ("binder") before you sign it:
- ✓ Have a new survey of the property made or an old one redated.
- ✓ Make sure there are no easements on the premises.
- ✓ Have a title search made.
- ✓ Try to get a full-covenant-and-warranty deed.
- ✓ Take out a title insurance policy.
- ✓ Let your lawyer represent you at the closing.

TUINAL...QUICK YET SUSTAINED SEDATION



Combines two cardinal features in a single preparation

There are equal parts of quick-acting 'Seconal Sodium'* and moderately long-acting 'Amytal Sodium'† in each Pulvule Tuinal. This assures your obstetric patient quick, sustained amnesia; your surgical patient relief from apprehension and fear.

Available in three convenient strengths—3/4, 1 1/2, and 3-grain pulvules.

*'Seconal Sodium' (Secobarbital Sodium, Lilly)
†'Amytal Sodium' (Amobarbital Sodium, Lilly)

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823000

That's why, when you're buying real estate, it pays to inspect the premises personally with an eye to possible easements.

4. *Liens and assessments.* More than one medical man has bought a home or office only to find that a mechanic's lien or an unpaid bill for back taxes came with it. Such obligations ordinarily can't be pinned on the seller if they're discovered after the closing.

How can you detect them? By having your lawyer or a title company make a preliminary title search. If encumbrances are found, you're legally entitled to a return of your deposit. (In some states, you can also collect for the full cost of the title search in any such event.)

5. *An invalid title.* When you buy property, how can you be sure there are no forged signatures on any of the legal papers affecting its chain of title? The truth is, you *can't* be sure.

Take the case of a New England physician who decided to buy an expensive home, which was owned by a married couple. When the closing took place, the seller's wife was abroad. So his secretary posed as the woman and forged her signature. Result: After the title changed hands, the seller's wife still retained her legal right to a share of the property—and said so. It cost the doctor plenty to clear his title.

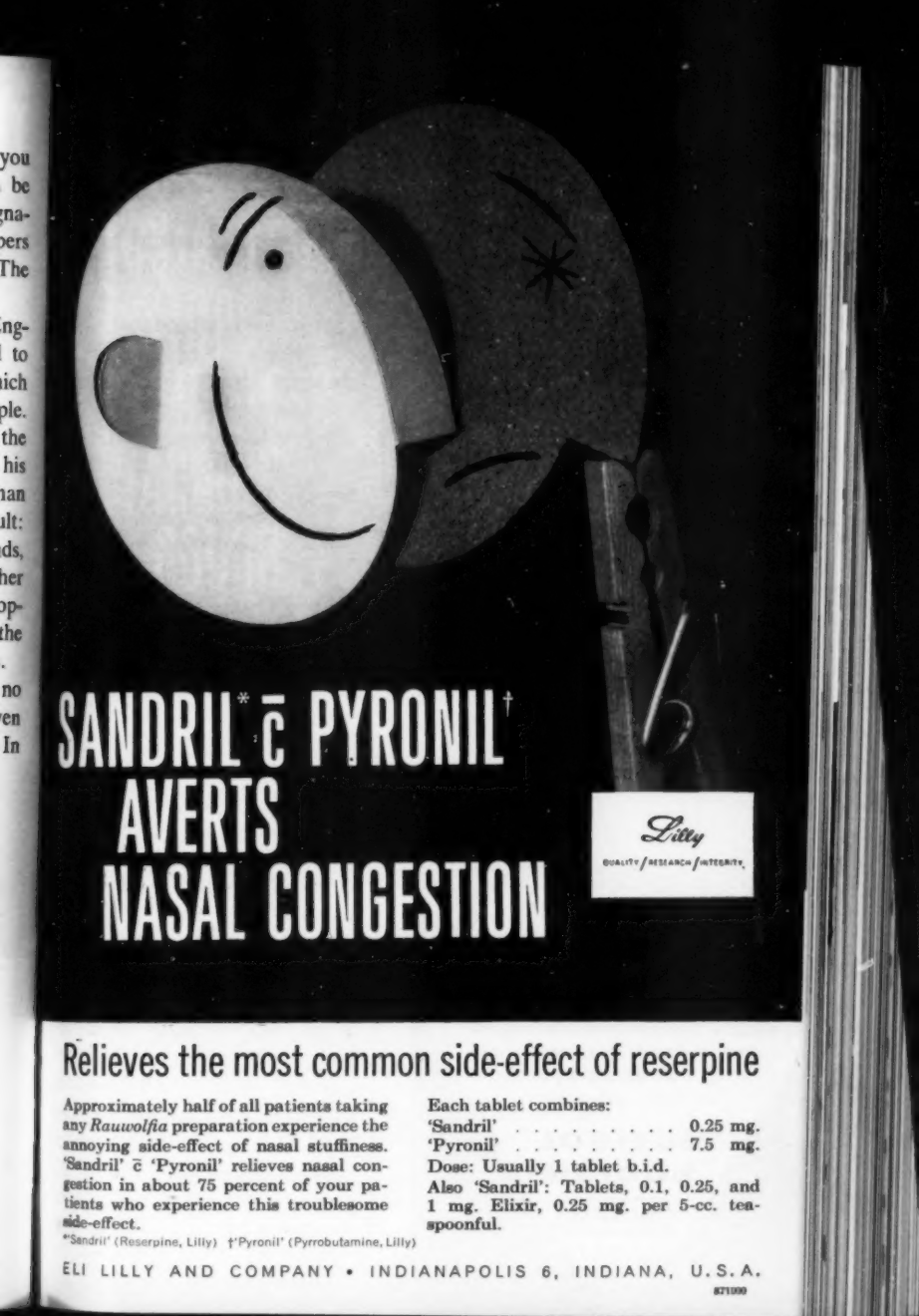
Sometimes the seller has no valid title to start with, even though he may think he has. In

How Much Is Enough?

The father of twelve children came to my office greatly disturbed. He told me his wife was threatening to leave him because he was losing his natural powers. I treated him for several weeks, with satisfying results.

Then his wife went to the hospital to have her thirteenth child. Imagine my feelings the next morning when I read in the paper that my patient had been arrested for trying to rape his mother-in-law!

—NATHAN MANN, M.D.



Relieves the most common side-effect of reserpine

Approximately half of all patients taking any *Rauwolfia* preparation experience the annoying side-effect of nasal stuffiness. 'Sandril' c 'Pyronil' relieves nasal congestion in about 75 percent of your patients who experience this troublesome side-effect.

Each tablet combines:
'Sandril' . . . . . 0.25 mg.
'Pyronil' . . . . . 7.5 mg.
Dose: Usually 1 tablet b.i.d.
Also 'Sandril': Tablets, 0.1, 0.25, and 1 mg. Elixir, 0.25 mg. per 5-cc. teaspoonful.

*'Sandril' (Reserpine, Lilly) †'Pyronil' (Pyrrobutamine, Lilly)

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one such case, a G.P. built his dream house and lived in it eight years before he found out he didn't own the land it was on. After all that time, a claimant to the property turned up. And it was discovered that his claim was valid, since a much earlier deed had been forged.

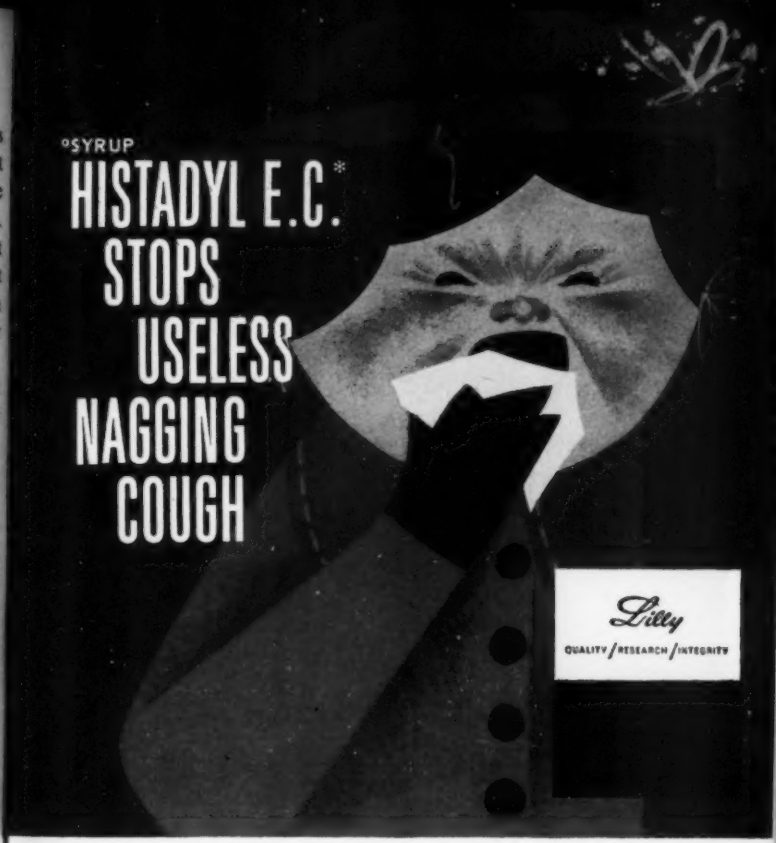
It cost three times the actual value of the land to reclaim it for the doctor.

His Deed Was Good

But the G.P. himself didn't lose a cent in this case. He was lucky enough to have a full-covenant-and-warranty deed. Such a deed binds the seller to protect the buyer against any successful challenge to his title—including unpaid mortgages, taxes, judgments, dowers, easements, and other claims—provided, of course, that the seller is alive, can be found, and has adequate financial resources.

So, since a full-covenant-and-warranty deed is the safest possible kind, you'll do well to try to get one. But many sellers refuse to accept such a blanket obligation. What you'll probably have to take is a bargain-and-sale deed. This signifies that the seller *believes* he has good title to the property but makes no guarantee that he has.

MORE▶



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Consider 'Histadyl E.C.' for your coughers of all ages.

Each tasty teaspoonful provides:	
Codeine Phosphate	1/6 gr.
Thenylpyramine Fumarate	1/5 gr.
Ammonium Chloride	1 2/3 grs.
Ephedrine Hydrochloride	1/12 gr.

*Federal record of sale required.
°Histadyl E.C.' (Thenylpyramine Compound E.C., Lilly)

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There's only one good insurance against the unpredictable risks involved in any such transaction. Its name is *title insurance*.

You can—and probably should—buy it in an amount equal to the value of your property. The coverage will give both you and your heirs complete security for as long as you hold title. In other words, it will reimburse you for any losses that you may sustain as a result of unexpected liens, assessments, or title defects.

What's more, if your title is ever attacked, the insurance company will handle the case for you and pay any legal fees involved.

The cost of such a policy: a single premium, amounting, as a rule, to less than 1 per cent of the value of the property you're buying.

Watch Legal Details!

One last word of advice: Don't jeopardize your own deed by failing to comply with such legal requirements as revenue stamps, a seal, witnesses' signatures, and formal recording at the county courthouse. END

AGE . . . In older people, chronic constipation and biliary dyspepsia are often the result of decreased food and water intake, inactivity, intestinal muscle atonicity, increased anorectal disorders, biliary stasis.

for biliary dyspepsia and constipation

OCCUPATION . . . Among the sedentary workers, chronic constipation and impaired digestion are often the result of lack of exercise which retards normal peristaltic action in the gastrointestinal tract.

Tablets of Caroid and Bile Salts with Phenolphthalein are specifically formulated to provide a 3-way, comprehensive approach to the problem of impaired digestion and elimination.

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2. **DIGESTANT**
3. **LAXATIVE**

Bile salts stimulate biliary flow for improved fat emulsification while Caroid steps up protein digestion up to 15%. Gentle stimulant laxatives induce formed, easily passed stools.

For patients who cannot or will not be managed by diet and exercise, Caroid and Bile Salts helps establish normal physiological patterns.

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CAROID® AND BILE SALTS *Tablets*

National Value Scale May Help You Set Fees

It's still in the future but probably coming, A.M.A. leaders say. Here's their consensus as expressed privately last month—and its meaning for you

By Hugh C. Sherwood

How much more should a doctor charge for an appendectomy than for a tonsillectomy? How much higher should he set his fee for a house call than for a hospital visit?

If you've been perplexed by such questions of relativity, you're not alone. They've long puzzled a good many of your colleagues too. They know that for an appendectomy some physicians charge twice the amount they charge for a tonsillectomy; others set these fees in the ratio of 3 to 1 or 4 to 1. Which, they wonder, is the most logical relationship between the two?

In the not too distant future, you and your colleagues may get substantial help with such problems from the A.M.A. For more than two years, its Committee on Medical Practices has been moving ahead with a so-

called relative value study.[1] Insiders now predict that the end result will probably be a national relative value scale for both medical and surgical procedures.

Point System

A relative value scale, remember, is not the same as a fee schedule. Instead, it rates the relative worth of procedures *in points*. The individual doctor can use it to establish the same relationships in his own fee schedule; but how he translates points into dollars is entirely up to him.

For example, according to the relative value scale approved two years ago by the California Medical Association,[2] a routine hospital visit is worth one point; a night call to a patient's home is worth two and a half points. Following this scale, a country doctor might charge $3 for the hospital visit and $7.50 for the night call. A city doctor might charge

[1]The committee is headed by Dr. Warde B. Allan of Baltimore, Md. Other members include Drs. Lester D. Bibler of Indianapolis, Ind.; W. Andrew Bunten of Cheyenne, Wyo.; R. B. Robins of Camden, Ark.; and Elmer G. Shelley of North East, Pa.

[2]See "Value Scale Spurs Insurance Pay," MEDICAL ECONOMICS, July, 1956.

for middle-age slowdown

Plestran is indicated as an aid in restoration of vigor in middle-aged or elderly patients who complain of chronic fatigue... reduced vitality... low physical reserve . . . impaired work capacity . . . depression . . . muscular aches and pains . . . or cold intolerance. Such "signs of aging," far from being due to physiologic disturbances, may often result from endocrine imbalance, especially gonadal and thyroid dysfunction.[1-4] Plestran provides ethinyl estradiol (0.005 mg.); methyltestosterone (2.5 mg.), and Proloid®* (¼ gr.)—hormones which help to correct endocrine imbalance and often halt or reverse involutional and degenerative changes.[1-4]

Plestran restores work capacity and a sense of well-being, usually within 7 to 10 days. It improves nitrogen balance, leads to better muscle tone and vigor, enhances mental alertness, helps to correct osteoporosis, senile skin and hair texture changes and relieves muscular pain.

The anabolic and tonic effects of the hormones in Plestran appear to be enhanced by combination so that small dosages are very effective. Combination also overcomes some of the disadvantages of therapy with a single sex hormone, such as virilization, feminization or withdrawal bleeding.[5]

Dosage: Usually one tablet daily; occasional patients may require two tablets daily, depending on clinical response.

Supplied in bottles of 100 and 500.

*Purified thyroid globulin

References: 1. McGavack, T. H.: Geriatrics 5:151 (May-June) 1950. 2. Masters, W. H.: Obst. & Gynec. 8:61 (July) 1956. 3. Kimble, S. T., and Stieglitz, E. J.: Geriatrics 7:20 (Jan.-Feb.) 1952. 4. Kountz, W. B., and Chieffi, M.: Geriatrics 2:344 (Nov.-Dec.) 1947. 5. Birnberg, C. H., and Kurzrok, R.: J. Am. Geriatrics Soc. 3:656 (Sept.) 1955.

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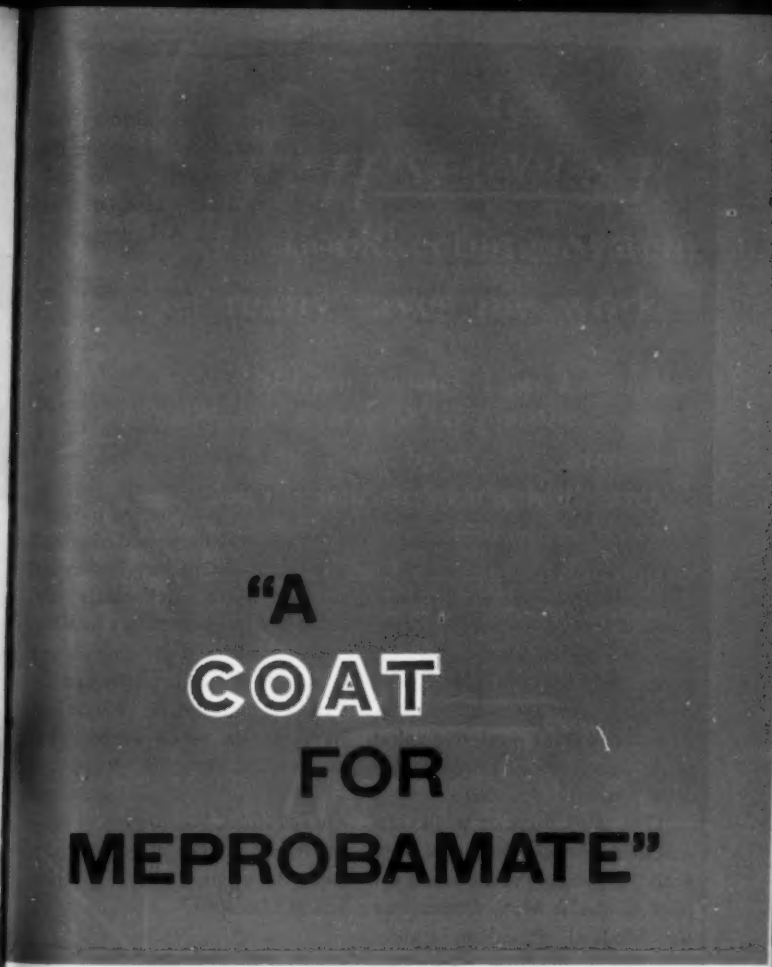
$4 for the hospital visit and $10 for the night call. Both men would be using the scale as it's meant to be used: as a guide to fee relationships, not as a substitute for individual fee-setting.

Useful Everywhere

Can such a guide be developed that will be useful from coast to coast? There seems no reason why not. Doctors differ in skill and experience; living costs vary from region to region; but these variables can be reflected in different fee levels without altering the most logical fee *relationships*.

If the A.M.A. committee eventually comes up with a national relative value scale, will the association's House of Delegates formally endorse it? Last month some of its best-informed members said privately there was a strong possibility the House would vote for any reasonable value scale whenever it was presented. Remarked one prominent East Coast surgeon:

"I'd vote for it tomorrow. And while I think it may take a little time to get a substantial majority in back of it, I'm convinced that some day we're going to have



"Meprotabs" are new, *coated*, white, unmarked 400 mg. tablets of meprobamate. ▪ "Meprotabs" are pleasant tasting, and easy to swallow. ▪ In this new form, the nature of medication is not identifiable by the patient. ▪ "Meprotabs" are indicated for the relief of anxiety, tension and muscle spasm in everyday practice. ▪ *Usual dosage:* One or two tablets t.i.d. **"Meprotabs"**

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(2-methyl-2-n-propyl-1,3-propanediol dicarbamate)

such a scale on a nation-wide basis."

Some delegates support the idea because they personally want help in setting fees. Others see it as a way of boosting the status of *medical* men. In the words of one of them: "Most insurance schedules give G.P.s and internists the dirty end of the stick. A value scale would help remedy the problem."

Boost Medical Fees

Many other medical men in the House of Delegates seem to feel that way. They point out that insurance schedules usually take surgical fees as a starting point; since it's an expensive starting point, fees for medical procedures are often set as low as possible. They think a relative value scale would mean fairer insurance payments for them.

They also think it would do much to boost their standing with the public. As the latest report of the A.M.A. Committee on Medical Practices states: "Medicine and surgery complement each other, and now is the time to make the worth of one as fully appreciated as the other."

If a relative value scale would mean better public relations for *medical* men, its supporters think it would mean better public relations for the rest of the profession too. Here's how Dr. Sam G. Jameson, an Arkansas urologist, states the case:

"If a patient knows what his doctor charges for one procedure, he can study a relative value scale and get a pretty good idea of what he's likely to charge for another. Thus a value scale would dispose of one big problem in patient relations: how to justify a fee to a puzzled patient.

"Such a scale would also enable a patient to buy health insurance more intelligently. By comparing a given plan's benefits with a scale, he'd get a good idea of just how much protection he was being offered. So he'd be less likely to be taken in by slick salesmen. And as everyone knows, patients are apt to blame not salesmen, but doctors, if their insurance coverage doesn't turn out to be as good as they thought it was."

Fair Starting Point

California's relative value scale obviously gives the A.M.A. committee something to start with. But many supporters of a national scale hope the commit-

tee will improve on it. For California doctors actually have not one value scale, but four: medical, surgical, radiological, and pathological. Thus, medical procedures are evaluated in relation to other medical procedures—but not in relation to the three other categories.

There's considerable feeling that the A.M.A. committee should develop a single scale relating medical and surgical procedures at least.

If and when it does develop such a scale, it's bound to run into some opposition. Much of it will probably come from delegates who distrust long-range national action on anything related to individual medical practice. One of them has already warned: "Once you set up relative values, you do it for all time."

Another man has said: "If a national value scale is produced and published, public opinion will *force* doctors to go along with it, even if they disagree with the fee relationships it sets up. And that's bad."

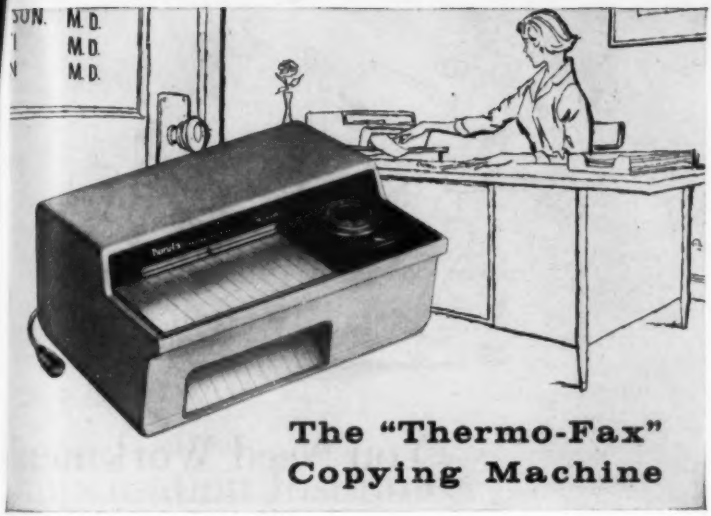
None the less, support for a relative value scale seems high. And while it may take the Committee on Medical Practices many months before it decides what it can recommend, you'll be hearing a lot of talk about such a scale from now on. As a prominent Southern delegate observes: "The more talk you hear about a good thing, the better are its chances for approval." END

Down But Not Out

I was performing a routine herniorrhaphy on a male patient. The spinal anesthesia had been administered, and the operation proceeded in silence.

As I reached to take a gauze pack from the nurse's extended forceps, it dropped to the floor and a reflex exclamation escaped me: "Oops!"

From behind the tentlike arrangement of the sheets concealing me from the patient came an apprehensive roar: "Whaddaya mean, 'Oops'?" —BERNARD DOLIN, M.D.



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You Need Workmen's

A Midwestern physician recently sent his receptionist on an errand in his car. She skidded off the road, was thrown against the windshield, and suffered severe facial abrasions and shock.

The doctor later suffered a shock of his own: He discovered that the receptionist was covered by the Workmen's Compensation law of his state; and so she was entitled to payment for medical expenses and lost wages.

His automobile liability insurance policy, which gave full protection for anyone else injured in the car, didn't apply to Compensation cases. And the receptionist's hospitalization policy, bought and paid for by the doctor himself, didn't apply either. Every penny of the amount the court awarded her came out of his own pocket.

"Most doctors treat Workmen's Compensation cases almost daily. But I'm afraid few doctors realize how the law affects them *as employers,*" says J. Dewey Dorsett, general manager of the Association of Casualty and

It's the only kind of insurance that can really protect you against the expense of injuries to your office assistants, warns this writer

By Joel Berg

n's Compensation Insurance

Surety Companies. The practice of medicine is just another business as far as such laws are concerned, he explains. That means there are no special exemptions for the nurses, receptionists, or medical technicians who work for you.

If the law of your state applies to you, it imposes obligations that simply can't be avoided. It fixes a scale of benefits for injuries arising out of the course of employment. And who foots the bill? *You* do—unless you carry a special Workmen's Compensation insurance policy.

Such policies are sold by insurance companies or (in some states) by state funds. They provide complete coverage to meet the state laws. Your state may *require* you to carry the insurance. But even if it doesn't, you'd be ill advised not to do so, in view of the scope of modern liability trends.

There was a time when an injured employe had to

sue for damages and prove negligence on the part of his employer. The latter could defend the charge by showing that the employe had voluntarily assumed the risks of the job, or that his

Check Your State's Requirements

In This Jurisdiction	Workmen's Compensation Insurance Is . . .	If Number Of Employes[1] Is at Least . . .	In This Jurisdiction	Workmen's Compensation Insurance Is . . .	If Number Of Employes[1] Is at Least . . .
Ala.	Elective	8	Neb.	Elective	1
Ariz.	Compulsory	3	Nev.	Compulsory	2
Ark.	Compulsory	5	N.H.	Compulsory	5
Calif.	Compulsory	1	N.J.	Elective	1
Colo.	Elective	4	N.M.	Elective[2]	4
Conn.	Elective	3	N.Y.	Compulsory[4]	1
Del.	Compulsory	3	N.C.	Elective	5
D.C.	Compulsory	1	N.D.	Compulsory	1
Fla.	Elective	3	Ohio	Compulsory	3
Ga.	Elective	10	Okla.	Compulsory[4]	2
Idaho	Compulsory	1	Ore.	Elective[4]	1
Ill.	Compulsory[2]	1	Pa.	Elective	1
Ind.	Elective	1	R.I.	Compulsory	4
Iowa	Elective	1	S.C.	Elective	15
Kan.	Elective[3]	5	S.D.	Elective	1
Ky.	Elective	3	Tenn.	Elective	5
La.	Elective[4]	1	Tex.	Elective	3
Me.	Elective	6	Utah	Compulsory	1
Md.	Compulsory[2]	1	Vt.	Elective	6
Mass.	Compulsory	4	Va.	Compulsory	7
Mich.	Compulsory	4	Wash.	Compulsory[4]	1
Minn.	Compulsory	1	W.Va.	Elective	1
Miss.	Compulsory	8	Wis.	Compulsory	3
Mo.	Elective	10	Wyo.	Compulsory[2]	1
Mont.	Elective[4]	1			

[1]In most jurisdictions, casual workers and/or domestic servants are *not* covered by Workmen's Compensation laws. [2]For "extrahazardous" employment. [3]For "especially dangerous" employment. [4]For "hazardous" employment.

own negligence had caused the accident.

But today's Workmen's Compensation laws scrap the entire theory of negligence. They require the employer—either through insurance or out of his own pocket—to bear the cost of medical expenses and lost wages resulting from *any* industrial accident affecting his employes. And all the states, the District of Columbia, Alaska, Hawaii, and Puerto Rico have Workmen's Compensation laws on their books.

If the Compensation law of your state applies to you and you have no insurance, you forfeit all defenses against a suit brought by one of your employes. Your employe can win full Compensation benefits almost automatically, even if he caused the accident through his own carelessness.

Nor will any other insurance protection help you. Personal liability policies, auto insurance, and other casualty policies specifically exclude injuries to persons who are covered by a state Compensation law. So it's Workmen's Compensation insurance

or nothing. There's no other choice.

"Such coverage is almost as important to doctors as their malpractice insurance if they are subject to the law," says Dorsett. He points out that most legal claims are one-shot affairs: If you lose the suit, you pay—and try to forget it. A Workmen's Compensation claim is more like alimony: You go right on paying, with no certain ceiling on the total amount.

MORE▶

Amusing . . .
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Amazing . . .
Embarrassing . . .

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Contributions must be unpublished. They cannot be acknowledged or returned. Those not accepted within ninety days may be considered rejected.

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WORKMEN'S COMPENSATION

One state Compensation official tells about a nurse who slipped and broke her hip in 1950. The bones failed to knit; she has been a semi-invalid ever since. Her doctor-employer carried Compensation insurance; and it has paid the nurse $30 a week for her lost wages since 1950, in addition to all her doctor and hospital bills. She'll continue to get benefits as long as the disability lasts—perhaps for life.

What are the chances that you're subject to the Compensation law of your state? That de-

announcing a new concept

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the new injectable—inhibits allergic responses—promptly

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Treatment course: 1 ml. daily for 6–8 days. Eliminates skin-testing, special diets, and long-drawn-out desensitization procedures.

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- *seasonal rhinitis (Hay Fever)*
- *non-seasonal rhinitis (dust, dander, molds)*
- *allergic asthma*
- *hives, especially in infants*
- *food allergy*

reprints and literature available.

1. *Clin. Med. 2:1009, 1955.*
2. *Amer. Pract. & Digest Treat. 7:1447, 1956.*
3. *Clin. Med. 3:1059, 1956.*
4. *Unpublished data.*

available: multiple-dose vials containing 8 ml.—one average treatment course.

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T.M. Reg. U.S. Pat. Off.

pends mostly on the number of persons you employ.

Nearly 60 per cent of all doctors live in states that make them subject to Workmen's Compensation if they have even a single employe. And according to MEDICAL ECONOMICS' 8th Quadrennial Survey, 81 per cent of all physicians do employ at least one full- or part-time aide.

Odds Are For It

The more persons you employ, the greater your chance of being subject to Workmen's Compensation. More than three-quarters of all physicians live in states requiring coverage where there are more than two employes.

A few of the state laws apply only to "hazardous," "extrahazardous," or "especially dangerous" employment. But though you may not consider your office a particularly dangerous place, state law and the courts may decree otherwise. New York law, for one, says that the handling of such electrical appliances as X-ray machines, handling and storage of chemicals, and laboratory work are hazardous. MORE▶

Take a second look...
diagnose that price tag

IN the low-cost G-E PATRICIAN you'll find *true economy of purchase*. Admittedly, there may be x-ray units with slightly lower price tags. But when you make comparative evaluations —component by component— the PATRICIAN is at the head of its class. Here's why:

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- Independent tube stand—no table-mounted compromise. Assures absolute freedom in positioning tube to patient... simplifies radiographic positioning.
- Built-in quality and endurance? Yes! Both are always associated with G.E. X-Ray equipment. But look at a few other PATRICIAN features: 200-ma, 100-kvp, full-wave power ... electronic timing ... double-focus rotating-anode tube ... automatic reciprocating Bucky ... provision for adding a spot-film unit.

Check this low-cost way to multiply your professional efficiency with your G-E x-ray representative. Or use this handy coupon.

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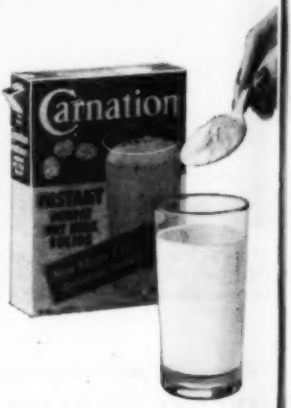
New Carnation Instant "self-enriched"

25% MORE PROTEIN, RICHER FLAVOR THAN ORDINARY NONFAT MILK!

Carnation Instant is a new crystal form of nonfat milk—and the *first* to bring Self-Enriched flavor and Self-Enriched nutritional advantages to low fat diets. Delicious for drinking, Carnation Instant enriches itself merely by the addition of one extra tablespoon of crystals per glass or ⅓ cup extra crystals per quart.

Result: "Difficult" patients stay on low fat diets. They respond to a richer and more palatable flavor, receive 25% more protein with each glassful—actually 41.3 grams of essential protein per quart.

CONVENIENT. And Carnation Instant is convenient, too — mixes instantly and completely even in ice-cold water–with a slight twirl. Ready to drink, immediately, *in the office,* at home or away from home. It's always cupboard-handy.



Big 9- x 16- inch chamber, bulk supply rack, two oversize trays; one 8½ x 15".

new!

No other autoclave like it...ever!

Castle's "999" has *everything!*

Styled with all the zestful good looks of a new car . . . and the precision of stop-watch control . . . the new "999" has everything you'll ever want in an autoclave.

Just look at these features:

Style—An autoclave you'll want "right up front." Everything's enclosed in a streamline casing finished in soft decorator colors . . . Coral, Green or Silvertone.

Simplicity—A cinch to run! The only double-shell autoclave with a *single control* for everything . . . filling, stand-by service, and sterilizing. As easy as push-button radio tuning.

Speed—Ultra fast! Double shell provides stand-by steam reserve for day-long sterilizing readiness . . . without waiting.

Safety—Foolproof! Safety door, safety fill, safety timer, safety valve and cut-off . . . plus all-important safety to your patients.

Convenience—A joy to own! Visible water gauge, reversible door swing, smooth, easy-to-clean surface.

Call or write us for a demonstration. The low price will amaze you.

THE WENDT-BRISTOL COMPANY

51 E. State St. CA 4-6108

1660 Neil Ave. WA-7048

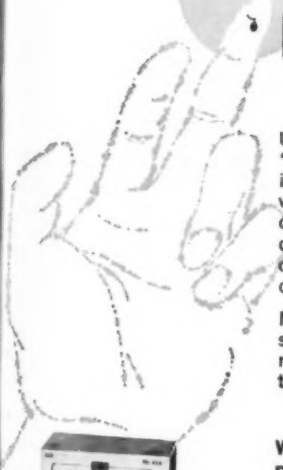
721 N. High St. CA 1-3153

Columbus, Ohio

now . . . easier, safer, controlled blood sampling

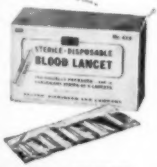
with the

B-D STERILE DISPOSABLE BLOOD LANCET



Unique point makes a half-round incision that "gapes", delaying clotting and closure; gives immediate adequate flow of blood without "milking" the finger with risk of diluting sample with tissue fluids. Side flanges control depth of penetration; angle and length of point assure incision in region of densest capillary supply with less trauma and pain.

Made of thin, rigid stainless steel; supplied sterile, hermetically sealed in aluminum foil, ready for immediate use. Inexpensive enough to be truly disposable.



We stock the B-D STERILE DISPOSABLE BLOOD LANCET in 250's and 100's:

No. 433 "250" Package consisting of 50 strips of 5 LANCETS each, individually perforated.

No. P433 "100" Package consisting of 5 aluminum canisters, each containing 20 individually sealed LANCETS.

B-D is a Registered Trademark of Becton, Dickinson and Company

THE WENDT-BRISTOL COMPANY

51 E. State St. CA 4-6108 | 1660 Neil Ave. WA-7048 | 721 N. High St. CA 1-3153

Columbus, Ohio

The practice of medicine has its own occupational hazard under the Compensation laws of forty-six states: communicable diseases. So if your aide contracts Asian flu, a court might well be asked to decide whether it can be traced to your office. Consider the following illustrations of this point:

¶ A Minnesota nurse worked with suspected TB patients who were later put in contagion wards. She contracted the disease herself—and won her suit for Compensation benefits.

¶ A male medical therapist in a western state suffered from rheumatoid arthritis, and the condition was aggravated by his work. The doctor who had employed him treated him without charge for five years; but the man later sued under the Compensation law and won.

¶ A nurse in a New York hospital stuck herself with a hypodermic needle while drawing blood. She contracted hepatitis —and collected benefits.

In certain types of cases, there's no time limit to bar suits under the Workmen's Compensation laws. One nurse developed

symptoms of too much radiation ten years after exposure. She put in a claim against the doctor she'd worked for a decade earlier. And the court allowed it.

Outside the Office

Finally, as I've already indicated, your responsibilities under the law can extend beyond the limits of your office. If your employes run errands, accompany you on calls, or take work home, they may be covered by the law all the while.

I know of a registered nurse who won benefits for an accident that occurred while she was washing her own car at her own home. She'd been on twenty-four-hour duty and had gone home for a rest period of four hours. But her Compensation went home right with her.

Even a Bullet Wound

Or take the Mississippi office aide who brought home some bookkeeping work one night. Her husband's gun was on the desk, and she pushed it aside. In doing so, she accidentally discharged it and was wounded. Ruled the court: The injury was

One 'Dexamyl' *Spansule* capsule, taken in the morning, will:

- provide daylong control of appetite
- calm tension, anxiety and irritability, producing an attitude of cheerful optimism

Dexamyl* Spansule*

Dexedrine* (dextroamphetamine sulfate, S.K.F.) and amobarbital — sustained release capsules, S.K.F.

2 dosage strengths: No. 1 and No. 2

*T.M. Reg. U.S. Pat. Off.

One 'Dexedrine' *Spansule* capsule, taken in the morning, will:

- provide daylong control of appetite
- replace listlessness, apathy and tiredness with a more nearly normal feeling of energy and well-being

Dexedrine* Spansule*

dextro-amphetamine sulfate, S.K.F. — sustained release capsules, S.K.F.

3 dosage strengths: 5 mg. (new), 10 mg. and 15 mg.

first SKF in sustained release oral medication

a direct result of her job, since she'd needed the desk to do her office work and had therefore been compelled to move the loaded gun.

What 'Elective' Means

As I've indicated, Workmen's Compensation insurance coverage is compulsory in some states. In the rest it's merely "elective." But that's a deceptive word. You can refuse to carry Compensation insurance in states with elective laws; but you still lose your defenses against suit. And in a few such states you may be subject to extra penalties for failing to insure.

Even when there is no legal penalty, though, the potential economic penalty is obvious. So the value of such an insurance policy is unquestionable: It makes you immune to employe suits; the employe must accept the benefits provided by the Compensation law. And, of course, the insurance company will pay all bills and handle the legal details connected with a Compensation case.

You can buy Workmen's Compensation insurance either

through a private casualty company or a state-operated fund. The latter method is the only legal one in eight jurisdictions: Nevada, North Dakota, Ohio, Oregon, Washington, West Virginia, Wyoming, and Puerto Rico. In most other areas, you can get coverage through your regular insurance agent.

Cost Is Low

And it's one of the lowest-priced forms of insurance you can buy. Though premiums vary somewhat from state to state, you can generally cover one employe for $25 to $50 a year. The cost increases with the size of your payroll. In New Jersey, for example, the premium is 37 cents per $100 of your annual payroll, plus $10, with a minimum total of $12. In Washington, D.C., it's 60 cents per $100, plus $10, with a minimum of $19.

So for your own peace of mind, better investigate how the Workmen's Compensation law of your state affects you. The chart on page 158 will give you a hint of where you stand. Ask your insurance agent to fill you in on the details. END

CLINICAL experience in the treatment of respiratory tract infections with SIGNEMYCIN* V

OLEANDOMYCIN TETRACYCLINE BUFFERED

acute pharyngitis
pneumonia, pleurisy
otitis media
bronchitis, sinusitis
bronchiectasis
tonsillitis, influenza
bronchopneumonia
pansinusitis, laryngitis
tracheitis, ethmoiditis
streptococcal pharyngitis
nasopharyngitis
tracheobronchitis
bacterial pneumonia due to resistant pneumococci, staphylococci, or mixed flora
viral or nonspecific pneumonia not responsive to other therapy
lung abscess
follicular tonsillitis
pharyngitis caused by resistant staphylococci, Streptococcus viridans, or hemolytic Streptococcus
lobar pneumonia, viral URI

of **934** patients with respiratory infections treated with Signemycin†[1]

875 patients showed an excellent or good response

38 patients had fair response

21 patients had a poor response

and with outstanding safety and toleration **914** patients had no side effects

Increasing use of Signemycin V and other Signemycin formulations has confirmed the value of this agent in the armamentarium of the physician treating antibiotic-susceptible infections, particularly those seen at home or in office where susceptibility testing may not be practicable and where immediate institution of the most broadly effective therapy is necessary.

References: 1. Case reports in the Pfizer Medical Department Files from fifty-three clinicians, and the following published reports: Shubin, H.: Antibiotic Med. & Clin. Therapy 4:174 (March) 1957. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. Winton, S. S., and Chesrow, E.: Ibid., p. 55. LaCaille, R. A., and Prigot, A.: Ibid., p. 19.

*Trademark †Trademark, oleandomycin tetracycline

Pfizer *World leader in antibiotic development and production*

PFIZER LABORATORIES, *Division, Chas. Pfizer & Co., Inc.*, Brooklyn 6, N. Y.

ASYMPTOMATIC ALERT
FOR 8-12 HOURS ON A SINGLE TABLET

Does the A.M.A. Need a Party Line?

It could use a more consistent set of policies, this study says. And a new group may supply it

By Robert L. Brenner

Some doctors have occasionally voiced the view that the A.M.A. was riding off in too many directions at once, without enough top-level coordination of divergent efforts. And now a management consulting firm hired by the A.M.A. has expressed the same idea.

According to Robert Heller & Associates, one of the "basic weaknesses" of the association is its lack of direction in matters of policy. The firm suggests strongly that the A.M.A. do something to crystallize its basic programs and objectives.

"Projects undertaken should receive closer scrutiny to assure that they are pertinent to the problems and interests of the Association," the Heller report says. And on issues that *are* pertinent, the A.M.A. shouldn't hesitate to take a firm stand.

Health insurance is a case in point, the Heller firm

minor chemical changes can mean major therapeutic improvements

Medrol*

The most efficient of all anti-inflammatory steroids

- Lower dosage (⅓ lower dosage than prednisolone)
- Better tolerated (less sodium retention, less gastric irritation)

*TRADEMARK FOR METHYLPREDNISOLONE, UPJOHN

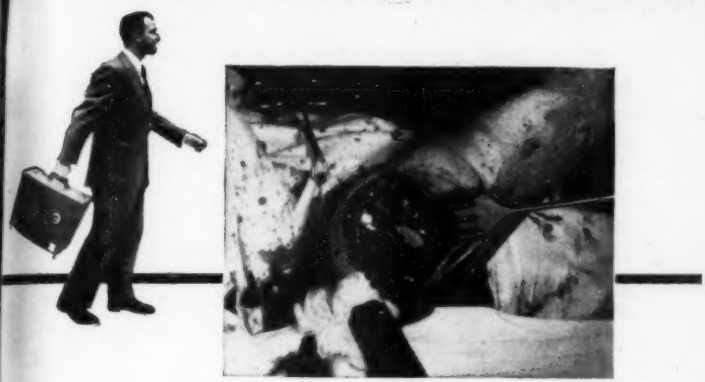
For complete information, consult your Upjohn representative, or write the Medical Department, The Upjohn Company, Kalamazoo, Michigan.

Upjohn

Supplied: Tablets of 4 mg., in bottles of 30, 100 and 500.

IN YOU COME . . . (Compact, one-case unit)

AWAY YOU GO . . . *(Handsome, luggage-type case)*



Easy to put on a perfect show with the Kodascope Pageant Sound Projector

Count on the Model 7K4 Pageant for brilliant screenings—*plus* ease of operation and maintenance. Auxiliary Kodak Microphone permits comments during showing of film; entire optical system is *Lumenized;* and the Kodak Projection Ektanon *f*/1.6 Lens has a built-in field sharpener assuring needle-sharp images, corner to corner. With 2-inch *f*/1.6 lens, 750-watt lamp, fully baffled 8-inch speaker, 1600-foot Kodascope Reel, $489 list. See your Kodak photographic dealer or write

Price is list and is subject to change without notice.

EASTMAN KODAK COMPANY
***Medical Division,* Rochester, N. Y.**

Serving medical progress through Photography and Radiography

Kodak
TRADE MARK

holds: Although the A.M.A. has come out in favor of voluntary health insurance, it has never set any minimum standards for health plans. And it has lost a chance for leadership because of this, Heller believes.

Failure to take firm stands on other important issues has hurt the A.M.A.'s prestige with both the profession and the public, Heller finds. In recent years, increasing numbers of physicians are said to have found that "their needs and interests were not being met by the A.M.A. . . . Now there are many national [medical] societies, each devoted to some particular segment of medicine. So today the A.M.A. . . . is no longer [medicine's] only authoritative voice."

The public, too, has come to consider other organizations (e.g., the American Cancer Society) as "perhaps more authoritative than the A.M.A.," adds the report. While the public "continues to regard the A.M.A. highly," it no longer considers the organization "the chief center of medical knowledge and information."

How can the association re-

gain this lost leadership? One answer, according to the Heller report, is for the association's policy-making bodies—its House of Delegates and its Board of Trustees—to supply this needed sense of direction. In other words, to set some sort of "party line."

But this sounds easier than it actually is. The delegates convene only twice a year. The trustees meet oftener—but, as one A.M.A. officer put it last month: "There just isn't time for them to pick out *all* the really vital issues as they come up. Sometimes important projects get sidetracked. And sometimes less important ones get too much attention."

Committee Created

A better answer may be to entrust a new committee with the task of continuously sharpening the A.M.A.'s "party line." The A.M.A. delegates hope so, anyway, because last month they voted to set up just such a group. Their Continuing Committee on Socio-Economic Policy (three members from the House of Delegates, three from the Board of

marked relief of spasm and stiffness
in a variety of "muscle complaints"...

flexin®

zoxazolamine*

enteric coated · plain

Effective up to 6 hours[1] with a single oral dose, FLEXIN provides gratifying relief of voluntary muscle spasm in low back syndrome, fibrosis, sprains, strains and in non-inflammatory rheumatic and arthritic disorders.

PACKAGING: Pink, enteric coated tablets (250 mg.), bottles of 36. Yellow scored tablets (250 mg.), bottles of 50.

REFERENCES: (1) Amols, W.: J.A.M.A. 160:742, (Mar. 3) 1956. (2) Smith, R. T., Kron, K. M., Peak, W. P., and Hermann, I. F.: J.A.M.A. 160:745, (Mar. 3) 1956.

WILLEN Laboratories, Inc · Philadelphia 32, Pa.

RESPONSE TO FLEXIN (after Smith and others[2])

Diagnosis	No. of Patients	Response		Per Cent Benefits
		Excellent	Good	
[illegible]	16	8	7	93.7
[illegible]	34	15	15	88.2
[illegible]	22	8	11	86.8
[illegible]matoid arthritis, mild	18	6	9	83.3
[illegible]collis, acute	2	2	..	100.0
[illegible]-traumatic muscle [illegible]m of low back	3	1	2	100.0
[illegible]oarthritis of hip	1	1	..	100.0

for the depressed and regressed

selective increase in psychic energy

MARSILID

(iproniazid)

Roche

In both mild and severe depression, Marsilid can restore a sense of healthy well-being, with renewed vigor, activity and interests. Patients with acute depression refractory to shock treatment have shown a heartening response to Marsilid. Even "burned out" psychotics, untouched by any other therapy, have become more alert, responsive and sociable.

As a psychic energizer, Marsilid is truly unique. It provides continuous mood improvement with gradually reduced dosage. Patients do not develop resistance to its normalizing effect; there is no tachyphylaxis. Marsilid does not elevate blood pressure . . . does not decrease but usually stimulates appetite.

In mild depression, improvement with Marsilid is usually evident within a week or two. In severe depressive states of hospitalized psychotics, a month or more may be required for apparent response . . . but Marsilid often leads to complete remission, obviating the need for shock therapy.

Note: Marsilid is contraindicated in patients who are agitated, overactive or overstimulated, or in those with a history of renal or hepatic disease.

For complete references and information concerning dosage, indications and contraindications, write V. D. Mattia, Jr., M. D., Director of Medical Information, Roche Laboratories, Division of Hoffmann-La Roche Inc, Nutley 10, N. J.

MARSILID® PHOSPHATE – brand of iproniazid phosphate

Supplied in scored tablets of 50 mg (yellow), 25 mg (orange), and 10 mg (pink)

ROCHE *Original Research in Medicine and Chemistry*

Trustees) now has these important assignments:

¶ To redefine the A.M.A. objectives and basic programs.

¶ To place more emphasis on scientific activities.

¶ To help create more cohesion among national medical societies.

¶ To study all important socio-economic problems.

'Most Important'

"This committee," said one A.M.A. officer last month, "could be one of the most important we've ever had. If it works as intended, it could be a major factor in helping organized medicine decide where it should be going—and in helping lead it there."

It won't supplant the A.M.A.'s policy-making bodies. It will select the issues that seem to require immediate A.M.A. decisions—and then help the policy-makers come to firm, consistent conclusions.

That's what the A.M.A. needs, according to Heller. And that's what the A.M.A. will get, according to the best predictions obtainable last month. END

[CONTINUED FROM 71] to that of the specialties."

The general practitioners think they have an answer to this. It's a provision for continued training after certification.

"We're going to certify our doctors for a limited time only," says one of the sponsors. "We'll be the only group that can guarantee our men are up-to-date. There'll be no deteriorated diplomates in our group. We know we can do it because we've insisted on post-graduate training as a requirement for continued membership in the Academy."

Founders of the new board expect some opposition from other groups in the profession. "Anyone who takes care of colds will eye us suspiciously," says one. "A lot of internists and pediatricians will no longer have much reason to feel superior."

Unexpected Support

But the opposition doesn't include a leading internist from an Eastern university. "Perhaps such a board will help to recreate internal medicine as the kind of specialty it started out to be," he says. "Then there'll be fewer in-

the chill

the cough

the aching muscles

the fever

Viral upper respiratory infection. . . . For this patient, your management will be twofold—prompt symptomatic relief plus the prevention and treatment of bacterial complications. PEN·VEE·*Cidin* backs your attack by broad, multiple action. It relieves aches and pains, and reduces fever. It counters depression and fatigue. It alleviates cough. It calms the emotional unrest. And it dependably combats bacterial invasion because it is the only preparation of its kind to contain penicillin V.

PEN·VEE·*Cidin*

Penicillin V with Salicylamide, Promethazine Hydrochloride, Phenacetin, and Mephentermine Sulfate, Wyeth

SUPPLIED: Capsules, bottles of 36. Each capsule contains 62.5 mg. (100,000 units) of penicillin V, 194 mg. of salicylamide, 6.25 mg. of promethazine hydrochloride, 130 mg. of phenacetin, and 3 mg. of mephentermine sulfate.

Wyeth

Philadelphia 1, Pa.

This advertisement conforms to the Code for Advertising of the Physicians' Council for Information on Child Health.

help reduce the pressures in your patients

Raudixin provides gradual, sustained lowering of blood pressure in hypertensive patients, as well as a mild bradycardia. Hence, the work load of the heart is reduced.

for total management of your hypertensi tient

RAUD

Squibb Whole Root Rauwolfia Serpentina

help reduce the pressures on your patients

Tranquilizing Raudixin helps relax the anxious hypertensive patient so that he is better able to cope with external pressures without being overwhelmed by them. By reducing these anxieties and tensions, Raudixin helps break the mental tension–hypertension cycle.

"...often preferred to reserpine in private practice because of the additional activity of the whole root."

Corrin, K. M.: Am. Pract. & Dig. Treatment 8:721 (May) 1957.

Dosage: Two 100 mg. tablets once daily; may be adjusted within range of 50 to 300 mg. *Supply:* 50 and 100 mg. tablets. Bottles of 100, 1000 and 5000.

sive dients rely upon

DIXIN

SQUIBB

Squibb Quality–
the Priceless
Ingredient

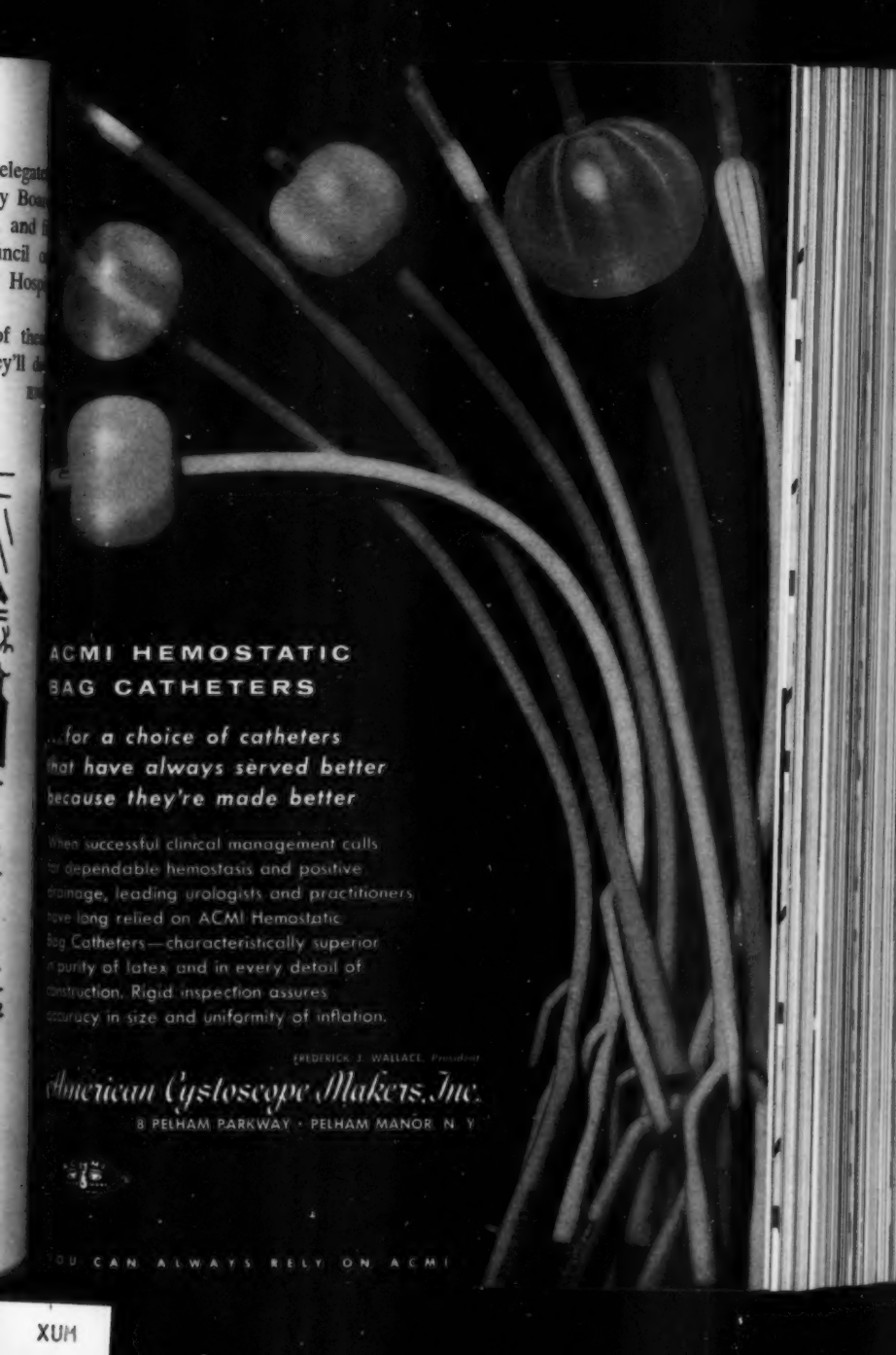
IN IS A SQUIBB TRADEMARK

ternists and they'll do referred work only."

Thus the sponsors of the new board may find support in unexpected places. Chances are they'll need it. They've got to put their plan across with the A.M.A. Section on General Practice, their own vociferous A.A.G.P. House of Delegate the formidable Advisory Boar for Medical Specialties, and f nally the A.M.A. Council o Medical Education and Hosp tals.

If they clear each of the hurdles successfully, they'll d serve a board diploma!

"Well, they said it was a house call."


ACMI HEMOSTATIC
BAG CATHETERS
...for a choice of catheters
that have always served better
because they're made better
When successful clinical management calls
for dependable hemostasis and positive
drainage, leading urologists and practitioners
have long relied on ACMI Hemostatic
Bag Catheters—characteristically superior
in purity of latex and in every detail of
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FREDERICK J. WALLACE, President
American Cystoscope Makers, Inc.
8 PELHAM PARKWAY · PELHAM MANOR N. Y.
YOU CAN ALWAYS RELY ON ACMI

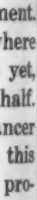
1 IN 4 NOW 1 IN 3

Ten years ago, only one in four cancer patients was being saved. Today, you, doctor, can expect to save one in three – thanks to your own leadership, a more aware public, improved techniques of diagnosis and treatment. We expect this progress to continue to the point where half of those stricken by cancer will be saved. As yet, science does not have the know-how to save the other half.

That knowledge will come when the riddle of cancer is solved in the research laboratories. To support this vital work, and to carry on its education and service programs, the American Cancer Society seeks $30,000,000 this Spring. We are again appealing to the public to "fight cancer with a checkup and a check."

The check is insurance for tomorrow. The insurance for today is largely in your hands, doctor. Fighting cancer with a checkup is our *immediate* hope for saving lives.

AMERICAN CANCER SOCIETY



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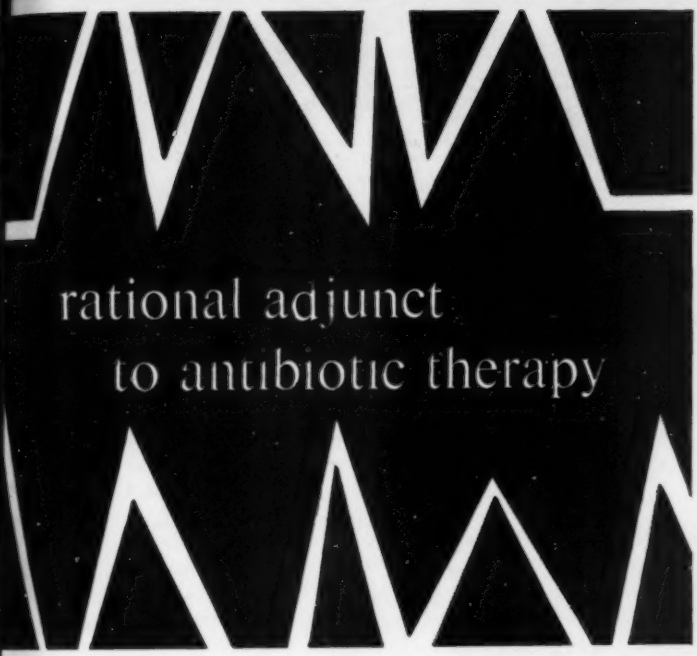

Current opinion stresses the desirability of supportive measures in the antibiotic treatment of severe infections.[1,2] In addition to protein, calories and electrolytes, the adjuvant use of STRESSCAPS speeds recovery by replenishing the specific water-soluble vitamin losses sustained by patients in stressful states.

Each Capsule Contains:

Thiamine Mononitrate (B_1)	10 mg.
Riboflavin (B_2)	10 mg.
Niacinamide	100 mg.
Ascorbic Acid (C)	300 mg.
Pyridoxine HCl (B_6)	2 mg.
Vitamin B_{12}	4 mcgm.
Folic Acid	1.5 mg.
Calcium Pantothenate	20 mg.
Vitamin K (Menadione)	2 mg.

Average Dose: 1-2 capsules daily.

STRESSCAPS in STRESS

• Infection • Physiologic Trauma • Endocrine Dysfunction • Emotional Stress • Pre- and Postoperatively

1. Pratt, R.: *Geriatrics* 11:341 (June) 1957. 2. Pulaski, E.J.: *Antibiotics Annual* 1953-1954, Proceedings of the Symposium on Antibiotics Sponsored By U. S. Department of Health, Education and Welfare, Food and Drug Administration, Division of Antibiotics, 1953, Medical Encyclopedia, Inc., New York, p. 227.

STRESSCAPS*

Stress Formula Vitamins *Lederle*

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, NEW YORK

*Reg. U. S. Pat. Off.

Memo

FROM THE PUBLISHER

First Evidence

In case you missed it, a special notice inside the mailing wrapper of this issue said:

"Here's the new fortnightly MEDICAL ECONOMICS. We've planned it to provide *timelier help* with the business side of your practice . . . plus *faster coverage* of important economic developments that may affect you personally . . ."

Timelier help . . . faster coverage . . . nice work if you can get it! Are you getting it in this first fortnightly issue?

You yourself are the best judge. As evidence, you may want to consider three articles in this issue:

¶ "G.P.s Plan Their Own Certifying Board." This story materialized in mid-December. It's important news for the country's 86,000 general practitioners. We couldn't have conveyed it to them until February on our old publication schedule. As it is, many of them got the word within two weeks.

¶ "National Value Scale May Help You Set Fees." Other publications covered the A.M.A. meetings in Philadelphia during December. There was no formal action on fees for them to report. But informal talks with A.M.A. delegates produced the story you'll find on page 147. It's of special interest to medical specialists.

¶ "Does the A.M.A. Need a Party Line?" Here's news for 133,000 active A.M.A. members. It's based on a study that has not yet been generally released.

These interpretive news stories are a type we haven't been able to run before—more complete than any weekly's news item, more up-to-the-minute than any monthly's news article.

Further evidence of our new fortnightly pace appears all through this issue. Witness:

The News Briefs round-up was written just a few days before this issue was mailed. "Do Your Savings Draw Maximum Interest?" reflects end-of-the-year developments. "Legislation Worth Watching" points toward Congressional hearings that begin next week.

There you have first evidence of what fortnightly publication means to you. Look for more every other Monday. —LANSING CHAPMAN